

Pulmonary Tuberculosis Follow-up

SIR,—I was greatly interested to read the letter of Dr. C. J. Stewart (12 September, p. 645) on pulmonary tuberculosis follow-up. It is certainly best to follow regularly all cases with apparently healed tuberculous lesions. But these cases pose a problem in the remote areas of the developing countries, where bad communications make regular follow-ups practically impossible. In these situations, it is perhaps better to treat them with isoniazid alone.

We have carried out 34,000 M.M.R. surveys of the 14+ age-group among refugees from East Pakistan resettled in this region and the local inhabitants belonging to different tribes. Of these, 699 cases were detected with shadows suggestive of active tuberculosis and were treated by conventional antituberculosis drug therapy. Another group of 265 cases presented doubtful shadows whose aetiology and activity could not be established immediately. As 81% of these cases were tuberculin-positive, as against 80% of the definite shadow cases, it is likely that these were inactive tuberculous lesions. Out of these 265 cases, 36 could not be traced, 164 were treated with isoniazid (300 mg once a day) for one year, and 65 were left untreated. The cases in the latter two groups were followed up after an interval of two to four years; the results are shown in the Table.

Result	Treated No. (%)	Untreated No. (%)
Improved	48 (23)	5 (8)
No change	114 (76)	57 (87)
Deteriorated	2 (1)	3 (5)
Total	164	65

These figures clearly show that treatment with isoniazid aided the improvement of about 15% of these cases (23% treated minus 8% untreated), and the incidence of reactivation was also lower in the treated group.

It may be asked if it is advisable to treat all the doubtful shadows for the benefit of only 15%. But in the absence of regular follow-up many of these 15% will not turn up for re-examination, at a great risk to themselves and the health of the general public.—I am, etc.,

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Students Doing House Jobs

SIR,—Last October the Medical Protection Society was asked by a representative of the British Medical Students' Association to consider the legal status of clinical students doing locum house jobs, with particular reference to any liability incurred by such students in respect of claims by patients based on allegations of negligence. Informally, a representative of the B.M.S.A. canvassed the possibility of the Society's offering membership to students in their final year who decide to undertake house officer locums.

Recently the council of the Medical Protection Society has considered this whole subject in the light of a letter from the Department of Health circulated to secretaries of boards of governors of teaching hospitals and a memorandum based on this circulated to the medical staff of a group of teaching hospitals; in addition

the council had received correspondence from the B.M.S.A. After a detailed review of the subject the Society's council decided to offer the following advice.

(1) That hospitals should not refer to students undertaking some of the duties of house officers either as "locums" or as "house officers."

(2) That negligence on the part of the supervising doctor would arise only if the latter had instructed the student to undertake duties he knew or should have known were beyond the student's knowledge or competence, or incorrectly or inadequately instructed the student in respect of any task allotted to him.

(3) In any case other than one arising under (2) above, the responsibility would be that of the hospital and not of the doctor or of the Society.

(4) That the supervising doctor should invariably be adequately experienced, and preferably should be named.

(5) That in the Society's view there appears little likelihood of liability falling upon students undertaking duties for house officers.

(6) Student house officers should not be permitted to prescribe dangerous drugs or Schedule 4 poisons.—I am, etc.,

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Secretary, Medical Protection Society

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Personal Health Services

SIR,—“As the old order changes, a personal health service is needed less.” (“Personal View,” 2 January, p. 45). One's first thought was that it must have been a misprint, but in the persistent absence of correction the paragraph was reread. However, even in the context of a plea for continued personal epistolary contact between family doctor and consultant it remained an idea that required contradiction.

It is true that the old order is changing in most types of service. From grocery supply through car maintenance to street cleaning personal contact between those serving and those served diminishes steadily. This change may be good economics and superficially appears more efficient, but it takes place at the expense of human contact, thereby making the life of everybody involved that much less worth living. The paragraph quoted seems to imply that medicine should follow grocery supply into a supermarket phase, becoming more efficient and effective as contacts between patients and doctors diminish.

It is difficult to give much credit to this idea. The basic transaction in medical care is completely personal, being a communication between two individuals—patient and doctor. The more they communicate in various ways the more likely it is that diagnosis and treatment will be successful. Without frequent contact and good communication there can be no understanding by the patient of his condition, or of what the doctor is trying to do to help him, and there will be less likelihood of recovery. Surely in the field of medicine, where personal communication is a basic ingredient of good quality work, administrative pressure to adopt supermarket methods should be deplored and resisted?

A personal service is needed more, not less. Most good family doctors are well aware of this but fear that the thesis is not held throughout the profession. Worse, they fear it is not being taught.—I am, etc.,

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Family Doctors' Pensions

SIR,—I am grateful for your note appended to my letter (9 January, p. 115), explaining the changes for which the Association is pressing in the method of arriving at family doctors' pensions. Granted that these changes would probably improve the pension prospects of younger doctors, it is not evident how they would help those who are approaching retirement in the near future when it is considered how meagrely we were paid for the majority of our service. In fact, it is only since the acceptance of the “charter” that we have received remuneration commensurate with our work, and all the earlier years of underpayment are bound to depress any pensions which are based on career earnings, as opposed to those based on the income in the final years of practice. I should not have thought that the latter method would be disadvantageous owing to declining income for those contemplating retirement at 65, although this might be true for those who stay on longer.

The question I asked about our compensation which has been in the deep-freeze since 1948 remains unanswered. Is the Association also pressing for justice for those of us who had our capital buried 23 years ago? Or are there too few of us?—I am, etc.,

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** The Secretary states: “The Chairmen of the General Medical Services Committee and the Compensation and Superannuation Committee have very recently met Sir Keith Joseph to discuss the outstanding compensation which is still owing to nearly 4,000 general practitioners.”—Ed., *B.M.J.*

Points from Letters

Public Health Doctors' Pay Increases

Dr. CHARLES W. BROOK (Bromley, Kent) writes: I was completely astonished to read the section on public health doctors' pay increases (*Supplement*, 9 January, p. 12). A summary was given prefaced by the following: “A settlement has now been reached in Committee C of the Medical and (Hospital) Dental Whitley Council, and new pay scales for public health medical officers have been promulgated with effect from 1 July 1970 to last for 15 months.” I have no knowledge as to whether the public health doctors, for whom I have the greatest respect, are satisfied with their increased remuneration, but what bewilders me is why the hospital doctors and those doctors in contract with an executive council cannot utilize the Whitley Council machinery.

As far as I am concerned, what is good enough for the Medical Officer of Health of the district in which I practise is good enough for me, and it is high time Sir Keith Joseph insists that hospital doctors and general practitioners should now make use of this valuable machinery.