general practitioner and his work—will be left out. It is probably some such ideas as these which have led to disquiet among general practitioners about the purpose and function of the General Practices Committee of the Central Health Services Council. The way in which this committee was formed was described by Dr. Dain (see this week's *Supplement*), and in what appears to be perfectly normal procedure there would not seem to be any reason for suspecting some dark Machiavellian motive. It should be recalled that in the earlier discussions on a comprehensive medical service the B.M.A. advocated the policy of central consultative bodies for all aspects of the service. It must be as much the concern of the Minister as it is of the medical profession that these central bodies, and their various committees, should command the confidence of those medical men and women who are doing the work in the surgery, in the hospital, and in the public health department. This confidence can be engendered only if the medical profession is satisfied that their representatives who sit on these councils and committees get there by accepted democratic methods. The Central Health Services Council, it may be recalled, is appointed by the Minister, who shall, according to the 1st Schedule of the National Health Service Act, "consult with such organizations as he may recognize as representative. . . ." It should be added that the Central Health Services Council and its various committees appoint their own chairmen: they are not appointed by the Minister. The appointment of the General Practices Committee, because of the width and importance of its terms of reference, has sharpened interest in the method by which professional representatives are chosen by the Central Health Services Council. Once such a body is established and sets up numerous committees to deal with this, that, and the other aspect of the health services there is the not unjustifiable suspicion that membership of them will be confined to a closed circus of trained performers.

While it may be agreed that the members have been chosen according to appropriate and customary procedure, the profession has the right to ask whether this procedure is necessarily the right one for obtaining the best results and, more important, for securing the confidence of general practitioners. Though it is perfectly true that the Minister has the constitutional right to choose his own advisers—and the profession would be in error if it tried to dictate to him who they should be—there would, to put it at its lowest, be no harm in consulting the B.M.A. as the representative organization of the profession about the membership of such an important committee as the one recently set up. Surely the late Minister would have disarmed criticism at once if he had asked the General Medical Services Committee to nominate one or more members; and it is anomalous to find as one of 22 members of the committee to consider general practice the secretary of an organization which represents 4,000 practitioners and not the Secretary of the B.M.A. And, too, it is curious to find that on this committee of 22 there is one member who, so far as we know, is neither a general practitioner nor a consultant, but a medical member of the Labour Party. This is not a question of personalities but a matter of principle.

Although we may be assured that under its chairman this committee will approach its task in an objective fashion, it should not be too late to strengthen the committee by adding one or two persons who, in addition to other general practitioners on it, command the respect of general practitioners as a whole. If the committee is to receive the evidence from the numerous bodies now investigating general practice and, on the basis of this, to formulate proposals for the consideration of the Central Health Services Council, it would seem unlikely that its findings would be reached until two or three years at the earliest, because it will be only by then that the observations of some of these bodies will be completed.

PINK DISEASE

To an already lengthy list of possible causes of what Swift, of Adelaide, originally called erythroedema, now more conveniently termed pink disease, colleagues in the same city have recently added hypofunction of the adrenal cortex, claiming rapid amelioration by giving salt and, in severe cases, deoxycortone acetate. Somewhat sensational accounts of this discovery in the lay press had perhaps a faintly discrediting effect, and it was therefore with some anticipation of getting the facts straight from one of the protagonists that the audience at the Ciba Foundation last December listened to Sir Stanton Hicks give the lecture which is printed in the opening pages of this issue. The story is quite fascinating. Dr. Donald Cheek, looking for some obscure mineral deficiency as an explanation for pink disease, found instead, with the assistance of a soil spectroscopist, subnormal plasma sodium in children with pink disease, without, at the time, appreciating the significance of this. Next, turning his attention to a possible overactivity of the adrenal medulla, Cheek consulted his physiological colleagues and then postulated a theory of underactivity of the adrenal cortex. All this paradoxical sort of approach would serve to colour the story only if the final result were more convincing. One speaker at the meeting, moving a vote of thanks

to Sir Stanton Hicks, stated that so far lowered sodium had not been found constantly in infants with pink disease in London, nor had treatment with salt proved effective.

Sir Stanton Hicks's description of the maturation of suprarenal function in the newborn and young infant is of great academic interest but scarcely relevant to the fundamental problem of pink disease, especially since his Table I, headed, like the lecture, "Some Typical Data from Cases of Pink Disease," gives results in eight children all between 2 and 5 years of age—well away from the newborn period and, incidentally, considerably older than the average age of sufferers from what is called pink disease in Great Britain. The theory of adrenal cortical insufficiency scarcely explains the unusually restricted age incidence, the almost epidemic nature of the disease at times and places, the great variation in its incidence in the experience of paediatricians in different parts of the world, or indeed, at perhaps the most elementary level, the curiously limited pinkness which gave the disease its name. It may of course be possible to explain other theories of aetiology by attributing the action of, for example, mercury poisoning, virus infection, or some vitamin or other deficiency to a final effect through the suprarenal cortex. The lecturer states boldly that "all the symptoms and signs can be explained in terms of the recognized results of loss of sodium with accompanying dehydration," but the clinical picture of pink disease is not the same as in dehydration after, for example, gastro-enteritis, even when chemical examination of the blood suggests a lowering of the sodium in a particular infant.

One possible conclusion to be drawn from the latest Adelaide theory is that what is termed pink disease in that city is something different from what is thus recognized elsewhere. Climatic and even soil conditions may determine a disturbance not exactly copied in other parts of the world. Perhaps the methods used by a soil spectroscopist reveal results not obtained by other forms of blood analysis. At all events readers can judge for themselves with the full text of the lecture available whether or not Sir Stanton Hicks has made out a convincing case. In one respect he has raised an issue about which some comment is necessary. The suggestion that "fractional cortical insufficiency" is the cause of vague ill-health—"cryptic manifestations of the pink disease syndrome" (in children aged 2 to 7 years)—failure to thrive, recurrent catarrh, the nervous child, and so forth—must not be accepted at this stage. The whole terminology is almost an exact repetition of the "acidosis" theory of vague ill-health in childhood, and such children, the cause of whose troubles, it is more and more recognized, is largely psychological, will perhaps now be dosed with salt instead of glucose. Such an approach is hardly scientific and will not advance paediatrics. It is in any case largely irrelevant to the subject of pink disease, which is, so to say, where the Adelaide workers came in. Everyone will agree with Sir Stanton Hicks in his conclusions about the importance of biochemistry to medicine to-day, but much clinical experience is necessary to interpret wisely the results of laboratory findings and to translate them into therapeutics.

SPRING CLEAN IN THE KITCHEN

Continued uneasiness about the standards of cleanliness in kitchens and work-places where food is prepared is reflected in the recent Parliamentary debate (reported at page 360) and in the reports[1] [2] of two working parties set up by the Minister of Food during the last two years. The field of inquiry covered by the catering trade working party, under the chairmanship of Sir William Savage, included all types of catering establishments from hotels to coffee-stalls. In its report this working party recommends two codes of practice—a "standard" code and a "target" code. The former contains the essential rules of hygiene for all restaurants, canteens, cafés, and those who work in them. It is of interest that three of the medical members of the working party thought that some of the recommended methods of preventing the infection of food by food handlers went beyond what is practicable. Under this section, for instance, a proprietor "should take reasonable steps to become aware of the existence among his staff of any of the conditions specified . . . or of any other illness." The target code, as its name implies, presents a long-term policy, with the emphasis on structural requirements and equipment.

The working party recommends that all catering establishments should be required to register with the appropriate local authority. The trade representatives accepted with some reluctance the idea that registration should be advocated as part of the administrative machinery to improve hygienic conditions in catering, and thought that if registration was necessary it should be "as of right"—i.e., that a caterer should merely notify a local authority that he intended to provide meals or food. The majority of the members, however, held the view that the premises should be inspected before registration is granted, in order to ensure that the public is property protected. Right of appeal against a local authority's refusal to register

1 *Hygiene in Catering Establishments*, 1951, H.M.S.O., London.
2 *Report of the Manufactured Meat Products Working Party*, 1950, H.M.S.O., London.
3 *Model Byelaws*: Series 1, 1949, H.M.S.O., London.
4 Parry, M., *Municipal Engineering*, 1949, **124**. 338
5 *British Medical Journal*, 1950, **2**, 613.