Control of Urinary Infections

SIR,—I am surprised that Mr. W. G. Q. Mills (December 24, p. 1884) has not yet heard of the eminently successful small-diameter polythene catheter invented by Mr. N. O. K. Gibbon, of the Liverpool Paraplegic Centre, Southport. I was one of the first patients on whom this catheter was used for prolonged bladder drainage in February, 1957, and can testify to its efficacy. I am a spinal paraplegic and required prolonged drainage at that time to clear up chronic infection. From the patient's point of view the catheter was eminently satisfactory.

May I refer Mr. Mills to an excellent article by Cosbie Ross, Gibbon, and Damanski,[1] of the Promenade Hospital, Southport, which was entitled "Recent Developments in the Treatment of the Paraplegic Bladder," and dealt very comprehensively with the subject? There seems no reason to suppose that the use of the polythene catheter described would be any different in the non-paraplegic bladder than it is in the automatic bladder of the paraplegic patient.—I am, etc.,

Headley Down, Hants. N. P. R. CLYDE.

REFERENCE

[1] Ross, J. Cosbie, Gibbon, N. O. K., and Damanski, M., *Lancet*, 1957, **2**, 520.

SIR,—Mr. W. G. Q. Mills (December 24, 1960, p. 1884) has rightly pointed out the need for a fine plastic catheter fitted with an inflatable balloon. This would be of great value in obese females and in males with scrotal swellings or obesity, in which cases external fixation of even a light plastic catheter[1] may prove difficult. Mr. Mills and others may be interested to know that Messrs. Wm. Warne and Co., Ltd., have supplied for trial a self-retaining plastic catheter (12 Charrière) with an inflatable rubber balloon which, though at an experimental stage, has given quite encouraging results. The drawbacks at present are that the cement joining the rubber to the plastic is somewhat unreliable, and that sterilization has to be carried out by ethylene oxide gas. I am hopeful that it will be only a matter of time before the technical difficulties are overcome.—I am, etc.,

Liverpool Regional Paraplegic Centre, Southport. NORMAN GIBBON.

REFERENCE

[1] Gibbon, N., *Brit. J. Urol.*, 1958, **30**, 1.

Radiological Hazards to Patients

SIR,—"Anonymous" (December 24, 1960, p. 1881) claims to identify an important radiological hazard—the radiologist. He wishes the Adrian Committee had taken steps to prevent general practitioners from referring their patients to radiologists "by-passing the out-patient department of the hospital and thus depriving the clinician [*sic*] of the chance of expressing his opinion." Clearly "Anonymous" does not consider either general practitioners or radiologists to be clinicians. This is false. Doctors in out-patient clinics, radiologists, and general practitioners are all clinicians. General practitioners could not practise modern medicine without direct access to ancillary aids. To deny them these is to waste their skill, to waste hospital beds, and to create a situation in which one group of doctors has a monopoly control over equipment. The examples quoted by "Anonymous" are no grounds in support of his argument. Hard cases make bad law.—I am, etc.,

The South-west London Mass *X*-ray Service, London S.W.6. F. A. NASH.

SIR,—I wish to protest against the remarks of your anonymous correspondent (December 24, 1960, p. 1881) concerning the use of *x*-ray facilities by general practitioners like myself. We are not mere clerks sign-posting every case that needs investigation to the nearest consultant.

I venture to suggest that general practitioners have enough clinical acumen to be able to determine which patients can be sent direct to the *x*-ray department, and furthermore can judge from the radiologist's report which patients can be dealt with by themselves and which require further investigation by a consultant. The example quoted by your correspondent appears to be an extreme case, and to suggest that general practitioners are adding to radiological hazards is in my opinion complete nonsense.—I am, etc.,

London E.3. BERNARD TAYLOR.

Electrocardiographs in General Practice

SIR,—We have carefully considered the letter of Dr. John W. Wigg (December 10, 1960, p. 1733) and would like to answer his several questions.

We have been using an electrocardiogram at the William Budd Health Centre since 1956 and find it very much worth while. It is a Philips Cardiolux model costing £296. With proper care in using it maintenance expenses can be reduced to a minimum. Only once in the four years has there been any need for a major overhaul, which was costly owing to the distance the representative had to travel. On other occasions the faults have been due to loose terminals which the sister can now adjust herself. All three nursing sisters at the centre very quickly learnt how to work the machine and can produce all the twelve leads required. It is small, compact, and portable, though its use is restricted to the centre as a matter of policy. It must be emphasized that the E.C.G. is limited in application as a diagnostic instrument and should be used only in association with clinical findings. It does not make a diagnosis by itself and, taken alone, a tracing can be very misleading. All the same we feel that it should be freely available to all G.P.s in common with other diagnostic procedures.

The most obvious saving is in the number of referrals to hospital out-patients; the E.C.G. is used two or three times a week (five firms, 12,000 patients at risk). On inquiry we find that this is comparable with hospital usage. We would hesitate to assess our competence to read the tracings, as we see relatively few, and for this reason we think it best to send all but the most obviously normal ones for consultant opinion. There is, however, no reason why any G.P. who wished to take the trouble should not become competent to read them himself. After all, we had to do this as students.

As to Dr. Wigg's first question whether we can use the E.C.G. with profit the answer is undoubtedly yes. We can deal now with most of our cardiac patients and maintain our clinical interest without having to refer them elsewhere. Out-patients profit because we save them a trip to hospital—a fair distance in our case. More important, we can get the result more quickly, and this is a great help in doubtful cases. There is also the psychological effect especially beneficial in "anxiety" cases. As for profit in its material sense, there is, of course, none. We do not charge for this service nor has it added a single patient to our lists. Its purchase for the individual practitioner is probably not justified, though a more widespread use would effect considerable

reduction in the price. It is certainly appreciated and used by all of us at this Health Centre.

We are informed that the manufacturers carry out a first-class maintenance service of two inspections annually for £10 10s.

—We are, etc.,

J. SLUGLETT. WILL SINTON.
H. I. HOWARD. D. H. FORSTER.
E. SAPHIER. K. M. HEWITT.
J. S. HUGHES GAMES. R. Y. CARTER.
E. J. LACE.

William Budd Health Centre, Bristol 4.

No Interview

SIR,—Like "Puzzled" (December 24, 1960, p. 1890), I am curious about the way in which London teaching hospitals select potential women medical students for interview. The particular case that interests me is that of a girl, also 18, with seven good "O" level passes (three over 80% marks), three "A" level passes, one at distinction level, one 74%, one 62%. She, too, was turned down by three London teaching hospitals without interview.

This experience, together with that of "Puzzled," is, of course, most reassuring. It is quite clear that the lady graduates of the older London teaching hospitals must be persons of Newtonian intelligence and of fantastically outstanding academic distinction, for not only have they been interviewed but even accepted after the interview.—I am, etc.,

Royal Infirmary, Manchester. D. LL. GRIFFITHS.

Oxford Medical School

SIR,—In his interesting Harveian Oration (December 24, 1960, p. 1821) Sir Francis Fraser states that after the establishment of clinical units in the London teaching hospitals, "there was little further development between the two world wars except for the appointment of a full-time professor of medicine at Bristol in 1935 and the establishment of the Postgraduate Medical School of London at Hammersmith." But what about Oxford? Two million pounds (and more) from Lord Nuffield, five clinical professorships with their departments, establishing a (mainly) postgraduate clinical school of some distinction. I am quite sure that Sir Francis's omission was due to a completely amiable slip of memory; but I hope future historians will not be misled. —I am, etc.,

Oxford. A. D. GARDNER.

POINTS FROM LETTERS

Radiological Hazards to Patients

Dr. JAMES F. BRAILSFORD (Birmingham 15) writes: I should like to give my full support to the letter signed "Anonymous" (December 24, p. 1881), which confirms the views expressed in an editorial in the *Journal of the International College of Surgeons* on "Roentgenograms: Their True Value to the Surgeon" (1960, **34**, 267). I should also like to comment on the letter by Dr. J. E. Parry (December 24, p. 1881). As a member of the Birmingham Medical School I would protest against his claim that they in Rhodesia "apparently give better service for minor injuries than you can get in Birmingham." I have no doubt that he and many others in Rhodesia endeavour to give patients the best treatment; but if he will consult the above-mentioned editorial he will see my reason for disagreeing with him.

Obituary

D. BAGSTER WILSON, O.B.E., M.D., M.R.C.P. D.T.M.&H.

Dr. D. Bagster Wilson, formerly director of the East African Institute of Malaria and Insect-borne Diseases, died suddenly at his home at Box, Wiltshire, on December 29, 1960, only a few months after he had retired from the East African Medical Service. He was 59 years of age.

Donald Bagster Wilson was born in 1901 and educated at Monkton Combe School, St. Catharine's College, Cambridge, and the Birmingham Medical School. Qualifying in 1926, he graduated B.Ch. at Cambridge in the following year and proceeded M.D. in 1935. Having taken the D.T.M.&H. in 1929, he joined the East African Medical Service in that year and was posted to Tanganyika. His first assignment was to make a short medical survey of the Africans of a coastal strip near Tanga. He was later appointed health officer to the Moshi–Arusha area of Tanganyika, and, in 1932, after a period of leave during which he married Dr. Margaret Elizabeth Lovett, a fellow student at Birmingham, he began what was to be his life work, the investigation of malaria, being given control of a newly constituted malaria unit at Tanga. The headquarters of this unit were later transferred to Old Moshi, and the survey work covered a wide area of the country until it was interrupted by the war.

Wilson joined the Army and was soon appointed to a malaria unit, attaining the rank of lieutenant-colonel and serving in Africa and Madagascar. After the war he continued his malaria work, and in 1949 he was appointed inter-territorial malariologist in charge of an East African malaria unit stationed at Amani, near Tanga; this unit was later expanded to become the East African Institute of Malaria and Insect-borne Diseases, and Wilson was its first director. The work involved research, teaching, and consultative work on malaria and other problems. After 10 years as director of this unit he retired in 1959, having been admitted M.R.C.P. in that year. He was appointed O.B.E. in 1953.

C. W. writes: Wilson's work, like his character, was consistent. He preferred to go deeply into a restricted field rather than to touch a wider field more superficially, and this characteristic—shared so completely by his wife, who was his close collaborator—was evident (as the writer remembers) from the first general survey near Tanga. There, and in his later malaria work, he examined relatively small numbers of people with great thoroughness, and later he and his wife, selecting the highly malarious village of Gombero as their observation area, month after month carried out the thousands of spleen and blood examinations, with tedious parasite counts, necessary to obtain a picture of the natural history of *Plasmodium falciparum* malaria at its highest intensity. The Wilsons had long been attracted to the epidemiological outlook of Christophers, James, Schüffner, and Swellengrebel, and appreciated and consistently emphasized the importance of acquired immunity in preserving the health of Africans in hyperendemic conditions, recognizing this not as a racial character (as had been supposed) but as a result of heavy and continuous infection. To disturb this immunity unduly, Wilson felt, might change the pattern to the detriment of the people, and he therefore advocated caution, giving minimum treatment so as to save life but to preserve immunity. He insisted that malaria in Africa is almost unique in its intensity, and that measures appropriate for India and elsewhere could not be assumed to be appropriate for Africa.

After the introduction of the residual insecticides Wilson organized widespread experiments—one very large one lasting several years in the Pare–Taveta area—which resulted in the finding that repeated spraying enormously reduced but did not eliminate infection. He remained reluctant to