G.M.C. Retention Fee

SIR,—The tone of your leading article *Patience Exhausted* (11 December, p. 637) is unlikely to help to resolve relations between the B.M.A. and G.M.C. An intra-professional civil war must be avoided at all costs. The G.M.C. is no foreign group seeking to impose controls and domination over its colleagues. Its members are reasonable and honourable men and women elected by the whole profession or by various professional bodies or appointed by the Crown. Most are also members of the B.M.A. The present President of the B.M.A. and its Chairman of Council are members, as are two former Presidents.

The functions and roles of the G.M.C. are under continuing discussion within that body and all of the suggestions made by the B.M.A. working party (*Supplement*, 11 December, p. 62) have been or are being considered. Any actions on such suggestions have to be balanced carefully as to any real benefits and as to whether they fit in with the statutory responsibilities of the G.M.C. It is dangerous to assume that an independent inquiry will lead to any better situation for the profession. Its recommendations may well be very different from what the B.M.A. working party would like.

The costs are great of running an independent body such as the G.M.C. that is empowered to maintain high professional standards. Management consultants and others do not believe that such costs could be reduced without considerable voluntary cooperation from the profession. If doctors paid their annual retention fees promptly and avoided the need for the cost of reminders, and if an improvement on the bankers' order system was accepted, then appreciable savings could be made. Streamlining of internal administration has been undertaken already and more is intended, but it would be wrong to expect much saving here. The profession has to decide that if it wants the G.M.C. to remain independent of Government it must pay for it. The most equitable form of contribution is by an annual fee, the recommended size of which is less than 1% of the recent award in increase of our remuneration. The Government is unlikely to accept arguments that it should contribute to the costs of the G.M.C. because the profession is hard up.

The subject of the G.M.C. has received a good deal of space in your columns. This should have resulted in a better understanding of that body and what it can and cannot do. The moment is ripe surely to bring together those in the profession with differing views to discuss the problems in a calm and reasonable manner. There are eleven members of the G.M.C. elected by the profession. They have responsibilities to their electorate. Could they not meet the working party of the B.M.A. that is to report on the functions of the G.M.C.?—I am, etc.,

JOHN FRY

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SIR,—I have read with incredulity that the G.M.C. proposes to increase the annual levy on the profession from £2 to £5 (*Supplement*, 11 December, p. 61) before the storm of protest about the introduction of the retention fee in the first instance has yet died down.

Many doctors, myself included, are entirely unconvinced by the arguments in favour of the retention fee, and I have always regretted the weakness of the B.M.A., which so nearly succeeded in stopping the whole thing at its inception.

Computerization of the *Medical Register* is one of the reasons given for necessitating the retention fee. This was intended to be an economic manoeuvre, and now, less than two years later, we are told to expect a 150% increase in the annual fee. I hope that the B.M.A. will not accept the proposal by the G.M.C., and I look forward with great interest this time to hearing how the G.M.C. explains the necessity for this increase.

I wonder if the arguments for the increase will be any more convincing than those propounded for the initial introduction of the fee.—I am, etc.,

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SIR,—May I congratulate you on your leading article (11 December, p. 637). In my opinion, the B.M.A. was mistaken in modifying the A.R.M.'s resolution that an annual retention fee be conditional on a review of the composition and functions of the B.M.A. While we should all welcome an inquiry into the finances of the G.M.C., this is meaningless unless coupled with an inquiry into its functions, and though this is implied in your leading article, it should be made perfectly clear. The G.M.C. holds to the view that its finances should be regarded independently of its functions, and in this argument may lie the present sorry state of its finances and the inefficient perpetuation of some of its functions.

I should also like to raise again the matter of its composition. The B.M.A. members of the Brynmor Jones committee too readily accepted the increase of elected representatives to 29 in order to achieve electoral parity within the G.M.C. This was a grave error. It merely enshrined the present university and college representation with the guarantee that new medical schools and new colleges would increase their number.

A balancing act by adding additional elected representatives is not only an unnecessary expense, but in the light of my experience would not have the desired result. It is doubtful whether more than a third of elected members would consistently press for B.M.A. policies in a G.M.C. as at present proposed. The answer is surely a much smaller G.M.C. with a two-thirds majority of elected members. That would be more economical, business-like, and more representative of the erstwhile functions of the G.M.C., leaving the universities and colleges a third of the places in respect of their special interest in medical education. It would not in any way prejudice the public interest and would provide the attractive alternative of a reduction of elected and other members, rather than the present system that guarantees perpetual growth.

While no one would doubt the honour and integrity of Sir Brynmor Jones, it was unfortunate that a sitting member of the G.M.C., who is the Vice-chancellor of the University of Hull, was appointed the chairman of the joint committee to advise on the future composition of the G.M.C. It was even more unfortunate that the Chancellor of the University of Hull should be Lord

Cohen of Birkenhead, the President of the G.M.C. In well-ordered circles this would not have been allowed.

In the past, when faced with proposals from outside and even from within, the G.M.C. has retreated to the argument that it is a statutory body and could not accept such proposals. This has not deterred it from putting forward its own proposals such as the inclusion in the 1969 Medical Act of authority to impose an annual retention fee. The G.M.C., like any statutory body, be it the Army or local authority, should be willing to accept criticism from outside, and, in the public interest, to act on it. Your leading article offers clear and constructive criticism and in my opinion is likely to be more effective than 29 elected members.

What is now needed is a truly independent inquiry into the functions, composition, and finances of the G.M.C. It may well show that with the new Industrial Relations Act and the registration of the B.M.A. as an agency, registration and discipline could be handed over to the B.M.A., which could equally accommodate nominees from the Privy Council to safeguard the public interest. As the Industrial Relations Act is now with us such considerations are urgent.—I am, etc.,

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"Medical Student in Hospital"

SIR,—The report of the National Conference of Hospital Medical Staffs (*Supplement*, 18 December, p. 83) emphasized the anxieties which are being felt in many quarters regarding the Department of Health's letter "Medical Student in Hospital." It seems worth while therefore to re-state the position regarding legal liability.

A student, like any other individual, has a personal liability for his own actions. He could therefore be sued. He is, however, acting as the agent of the hospital authority, and that authority has therefore a liability for his actions. In practice, therefore, it is the hospital authority and not the student who would be sued.

The hospital authority would quite properly consider whether any registered practitioner had been wholly or partly responsible for the student's act or omission. The protection organization representing any doctor who might thereby become involved will accept liability for their member if it be shown that he failed to give adequate instruction and/or supervision to the student. If, on the other hand, he gave adequate instruction and supervision and despite this the student acted negligently, the view of the Medical Protection Society would certainly be that the liability fell on the hospital authority.

It is not thought then that, in permitting themselves to be the "named cover" for students, registrars are putting themselves at any particular risk. While the Department's letter speaks of supervision being given "at all times" it is not thought that this means that the registrar must be day and night at the student's elbow. Such an interpretation must be rejected as being absurd. The adequacy of instruction and supervision would require to be looked into, having regard to all the relevant circumstances of each individual case.

May I close by assuring students that allegations of negligence in respect of their acts or omissions are very rare. They can, moreover, rely heavily on the abundant goodwill towards them that exists in the profession.—I am, etc.,

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*The question of the legal liability of medical students working in casualty departments has also been discussed recently by our Legal Correspondent (30 October 1971, p. 311).—Ed., B.M.J.

Examination of the Unconscious Patient

SIR,—Your leading article (6 November, p. 313) stressing the importance of carefully examining the unconscious patient provides a valuable service in emphasizing that bedside methods often provide the key to diagnosis in such circumstances. Since reversible metabolic processes or treatable supratentorial or subtentorial mass lesions can often be the cause of stupor and coma, the prompt and accurate interpretation of clinical signs can be life-saving.¹ However, our own experience about the significance of certain findings in such patients differs from that described in your leader and it may be helpful to mention these few points.

The major immediate clinical issues in the diagnosis of stupor and coma are usually to differentiate between structural and metabolic causes. With the structural lesions, one must distinguish between primary supratentorial and subtentorial abnormalities, since treatment has little to offer primary destructive lesions of the brain stem, but a great deal to offer in the presence of supratentorial masses, where effective action often prevents transtentorial herniation and subsequent irreversible brain-stem injury. These considerations make it of major importance to know the pathological anatomy and physiology that underlies certain signs and symptoms and how these signs combine and evolve in each major condition. Otherwise, one may erroneously conclude—for example, that the brain stem is threatened when it is not, or that a structural lesion has hopelessly damaged the brain when, in fact, reversible metabolic depression is the culprit.

To turn to specific points, our studies indicate that decerebrate posturing often accompanies extensive destructive or metabolic lesions confined to the hemispheres and the diencephalon and need not imply brain-stem dysfunction of mid brain, pons, or medulla. Bilateral pupillary dilatation on neck flexion is *not* a sign of impending tentorial herniation; in fact, although it sometimes accompanies brain disease, it can be a normal phenomenon easily elicited in drowsy young persons and probably represents no more than heightened ciliospinal reflexes. In contrast to your own experience, we find abnormalities in the pattern of breathing to be of considerable localizing value,² and at least as useful in appraising the locus and course of severe neurological illness as changes in the motor reflexes or behavioural responses to noxious stimulation. Finally, though fever admittedly has little specific neurological meaning, hypothermia deserves the physician's special attention for it almost

always means metabolic depression of the brain in acutely unconscious patients.

I support heartily your suggestion that neurological units geared to treat the unconscious patient offer much that is valuable to patients, staff, and students alike. This is true whether one confines this to strokes or widens the target to develop a comprehensive acute neurological-neurosurgical unit to care for all unconscious and severely injured neurological patients as we have done at the New York Hospital.—I am, etc.,

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¹ Plum, F., and Posner, J. B., *Diagnosis of Stupor and Coma*, 2nd edn., Philadelphia, F. A. Davis Co., 1972.

² Plum, F., in Ciba Foundation Symposium. *Breathing: Hering-Breuer Centenary Symposium*. London, Churchill, 1970.

Hepatitis and Hepatoma in the Tropics

SIR,—The discovery of the association between Australia antigen and viral hepatitis has provided a specific serological marker for at least a proportion of patients with serum hepatitis and carriers of this virus. Studies on the distribution of Australia antigen in normal populations in different geographical areas of the world revealed that this antigen was very rare or absent in normal North American and European communities, but that it occurred frequently (6-25%) in the serum of apparently healthy people living in the tropics and South-east Asia.¹ It has been suggested that this high frequency of Australia antigen in the tropics is due to tattooing, scarification, ritual operations such as circumcision, and transmission by blood-sucking insects.²

Chronic carriage of Australia antigen is common in patients with a defective immune response—for example, lepromatous leprosy, acute and chronic lymphocytic leukaemia, and chronic renal failure. It has been shown that a background of repeated parasitic infection induces a number of immunological changes and the immunosuppressive action of malaria is well recognized. For example, McGregor and Barr³ found a higher incidence of non-reactors to tetanus toxoid among malarious than non-malarious children in Gambia and there is considerable evidence of an early immune depression in plasmodial infection in mice.⁴ The high frequency of Australia antigen in the tropics may similarly be related to this immunological phenomenon.

The recent reports of the high incidence of Australia antigen in patients with liver cancer in Senegal, Uganda, and Kenya⁵ lends support to the view that such an association could well be of some aetiological significance. An altered immune reactivity in malaria may also affect the outcome of chronic infection with a virus by allowing the virus to become frankly oncogenic and or by interfering with the immune reaction to neoplastic cells. Indeed, an increased incidence of malignant lymphoma caused by murine oncogenic viruses in mice chronically infected with *Plasmodium berghei yoelli* has been demonstrated⁶ and the hypothesis that a similar mechanism operates in chronic infection with serum hepatitis is currently under investigation.—I am, etc.,

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- ¹ Blumberg, B. S., Friedlaender, J. S., Woodside, A., Sutnick, A. I., and London, W. T., *Proceedings of the National Academy of Sciences*, 1969, 62, 1108.
- ² Zuckerman, A. J., *Bulletin of the World Health Organization*, 1970, 42, 957.
- ³ McGregor, I. A., and Barr, M., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1962, 36, 364.
- ⁴ Salaman, M. H., Wedderburn, N., and Bruce-Chwatt, L. J., *Journal of General Microbiology*, 1969, 59, 383.
- ⁵ *Nature New Biology*, 1971, 232, 100.
- ⁶ Wedderburn, N., *Lancet*, 1970, 2, 1114.

Transrectal Prostatic Biopsy

SIR,—Mr. W. F. Hendry and Mr. J. P. Williams quote impressive figures in their interesting article on this subject (4 December, p. 595). However, I feel that their claim for a reliable diagnosis with the Franzen needle in 82% of cases is not substantiated. Using this technique, a proportion of results can only be classified by the cytologist as "suspicious but not definitely malignant." Without other evidence of malignancy, it is debatable whether treatment would be justified. Biopsy in such cases can be repeated and the number of indeterminate results reduced.¹ If "suspicious" results are excluded, the authors have achieved a definite and correct diagnosis in 100 out of 138 cases (72%).

There is the further problem that in clinical practice, cytology results are acceptable as sufficient evidence of malignancy. The authors claim as confirmation of their diagnosis improvement in obstructive symptoms following hormone therapy—a subjective assessment. Conversely, it has been stated that false positive results should not occur,² and the one apparent case in this series requires explanation.

These problems associated with interpretation of the results of Franzen needle biopsy require long term follow-up studies for their elucidation, but do not detract from the value of the technique as an outpatient procedure.—I am, etc.,

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- ¹ Sunderland, H., and Lederer, H., *British Journal of Urology*, 1971, 43, 603.
- ² Elkman, H., Hedberg, K., and Persson, P. S., *British Journal of Urology*, 1967, 39, 544.

Value of Coronary Care Units

SIR,—The controlled trial of home care compared to hospital treatment for myocardial infarction by Dr. H. G. Mather and others (7 August, p. 334) essentially gives evidence that it is ethical to do such a study. This report has resulted in considerable comment in the public press and among medical care specialists in the United States. We therefore find the relative absence of correspondence (21 August, p. 473; 4 September, p. 581; 18 September, p. 704) on this report somewhat puzzling. The randomized study of over 1,000 coronary episodes is a unique effort in determination of the effectiveness of the coronary care unit for monitored hospital care of myocardial infarction. It raises questions concerning the value of coronary care units in community hospitals and introduces a possible hospital-induced mortality effect.

It is certainly not to deny the undoubted value of some coronary care in specialized units to raise the question whether all patients with myocardial infarction receive