1949 Act which maintains the right to private practice by entitling doctors and dentists to work both privately and in NHS establishments; and thirdly, the establishment of an independent board to relate these commitments." A profession which has had such unhappy experience of allegedly "independent" Review Bodies in respect of pay should surely be profoundly sceptical about the independence of yet another body, involved in politically contentious issues, all of whose members would be appointed by Government. There are succeeding parts of the statement where it is made clear that, despite the establishment of a board, the Secretary of State would still be overseeing a number of the arrangements. In any case, who could really believe that such a board would be free from constant political interference and sniping?

In the event of an Act of Parliament legislating for the "phasing out" of private facilities, Lord Goodman goes on to list what he regards as safeguards. In para 3(a) the word "reasonable" appears four times in as many lines; the same word crops up again in 3(b) and on four further occasions in the subsections of 3(d), to be followed by "reasonably" on two occasions in 3(e). One is left with the strong feeling that the statement is a better basis for a lawyer's paradise than a foundation for future professional independence.

Para 3(g) refers to common waiting lists, presumably in the half-emasculated NHS. If this means that the private and general inpatients of each consultant shall be admitted from a single list then I am in favour of it. In common with others I have for years admitted all non-urgent cases, whether general or private, on a firm date excepting when deliberate delay was necessary for slimming and other purposes. However, many emergency private cases have been denied this facility for want of a pay-bed, while urgent private cases have often had to wait substantially longer than general ones. If Government, or a truly independent board, was prepared to ensure that urgent and emergency private patients can be guaranteed pay-beds with the same dispatch as general ones then this would be a real advance. But if the document is referring to common waiting lists for all outpatient clinics and investigations there could be real difficulties in many hospitals. This is especially true in a 100% free-at-the-time service and is one of the problems to which a royal commission should address itself with some vigour.

The most pernicious doctrine is in para 3(f)—"as stated in the Queen's Speech, the regulation of the private sector following the separation of pay beds will be subject to further consultation with the professions." After our experience with the "consultative document" (that misnamed near-Marxist tract published in August 1975 and demanding answers by the end of September) it is astonishing that Lord Goodman can expect the professions to have any remaining faith in the Government's interpretation of consultation. The only sane conclusion is that Lord Goodman's proposals must be considered with the "consultative document." That being so it surely behoves us all to treat these proposals with the uttermost circumspection and scepticism.

Radlett, Herts

REGINALD S MURLEY

SIR,—Mr Rudolf Klein (6 December, p 591) states in his discourse on private medicine that "remarkably little is known about the nature of this market in Britain" and that consequently his views are "inevitably speculative." He asks, "Why, in fact, do people buy treatment on the private market?" and speculates that the main reason is "because it allows them to queue-jump by getting quicker treatment than would be possible under the NHS." Sir Francis Avery Jones (27 December, p 761) states, "I believe there are very few patients who seek to 'buy time,' and 'queue-jumping based on the purse is relatively uncommon." He speculates that patients opt for the private sector "to get the most appropriate consultant." Who and what are we to believe?

Amidst this welter of speculation perhaps some selected objective data^{1,2} may be helpful. Of 694 NHS registered patients referred for specialist outpatient appointments, 139 (20%) opted for the private sector. The reasons given by the patients for so doing were: to bypass the outpatient waiting list (46%), to avoid waiting in the outpatient department (18%), to have the consultant of the patient's choice (18%), and other reasons (18%).

The mean waiting time for non-urgent NHS outpatient appointments was 41.7 days compared with 18.8 days in the private sector. The waiting time for urgent appointments was 10.1 days and 8.2 days respectively. The specialties with the longest mean waiting times for NHS appointments were ophthalmology (88.7 days), general surgery (61.4), and orthopaedics (49.4). The private-appointment waiting times were 32.2, 21.6, and 22.4 days respectively.

There is no doubt, therefore, that paying for a private consultation enables the patient to jump the NHS queue, as Mr Klein suggests. The figures also demonstrate the importance patients assign to prompt medical attention rather than "the most appropriate consultant," as Sir Francis suggests.

As has been demonstrated, private practice is sought mainly because of the rationing and delayed availability of the NHS. It is interesting to note that "East Midland patients who opted for the private appointments had to wait longer for these than for NHS appointments in SE England and London." In our so-called National Health Service it seems that regional inequality in the provision of resources is encouraging (or forcing?) people to opt for the private sector. Mr Klein states that "there is something morally repulsive in . . . being able to buy preferential medical treatment." I think it is "morally repulsive" for equal tax-paying citizens in the East Midlands to have to pay extra money for the privilege of waiting longer for their private ("preferential") consultations than NHS patients in London and SE England.

ROBIN C FRASER

Leicester

¹ Fraser, R C, MD Thesis, University of Aberdeen, 1974.

² Fraser, R C, Patterson, H R, and Peacock, E, *Journal of the Royal College of General Practitioners*, 1974, 24, 304.

Effect of junior doctors' action on self-poisoning

SIR,—I write to record the experience in this hospital of a dramatic reduction in the number of patients admitted for self-poisoning during the past three weeks of the junior doctors' industrial action.

Since it has appeared in the press that the

junior doctors are working a 40-hour week and despite the fact that in this hospital all departments are adequately covered for 24 hours, the number of cases admitted for the treatment of an overdose of drugs has fallen dramatically. This has been particularly noticeable on the female side; where we would have expected 12 cases by the end of the first 18 days of December only one has been admitted. Those cases in which a "suicidal" gesture is made and the patients know that they will receive treatment as soon as they are admitted to hospital have not been seen.

One can only conclude that it is the knowledge that prompt treatment in hospital for drugs taken in overdose quantities plays a large part in the decision of patients to carry out these "suicidal" gestures, and when this prompt treatment is in some doubt these gestures are not made.

G S CROCKETT

Kettering and District General Hospital,
Kettering, Northants

On surviving a bivouac at high altitude

SIR,—Your readers may be interested to know that one of our highest nights without supplementary oxygen was spent by the two Britons who made the first ascent of the south-west face of Everest. The ambient oxygen tension at this altitude is of the order of 50 mm Hg.

At 6 pm on 24 September 1975 Doug Scott and Dougal Haston reached the summit of Everest (29 028 ft (8848 m)) using oxygen on a demand system after a 14-hour climb. They left the top during the sunset and returned to the south summit, where they dug for themselves a snow hole on the Tibetan side at about 28 600 ft (8800 m). They were without food and without oxygen after 8 pm. The still air temperature was probably about -35°C ; they used a small propane-butane gas stove which lasted until midnight. They carried no extra clothing to meet this contingency, Haston wearing a down suit over a silk undersuit and one sweater, and Scott a windproof suit, a nylon pile suit, and one sweater over a silk undersuit. After an indescribably cold night they descended to camp 6 (27 000 ft (8200 m)) and then gradually down to the face during the day to camp 2 (22 000 ft (6700 m)), also without oxygen.

On examination on arrival at camp 2, despite being very tired, both gave a lucid account of their climb. They also told of a curious sensation that a third person had been sharing the snow hole during the night. The only findings on general examination were of intense sore throats, with tracheitis, and minor frostbite of several fingertips. There was no retinopathy.

Although several mountaineers have bivouacked above 28 000 ft (8500 m),¹ severe frostbite of the extremities has been usual. Hallucinations and delusions have been recorded since the pre-war Everest expeditions.²

These two experienced climbers owe their survival to their remarkable persistence in maintaining their body temperatures, by warming each other's extremities throughout the night and remaining awake despite particularly strenuous prolonged work at high altitude on the preceding day. It is relevant to mention that accidental hypothermia can

frequently be avoided if the subjects show the fixity of purpose described here; their determination to minimise the wind-chill factor (by digging a substantial snow cave) and to overcome the urge to sleep undoubtedly prevented a serious outcome for this party, which carried no specific equipment to spend a night out near the summit of Everest.

CHARLES CLARKE
Medical Officer,
British Everest Expedition, 1975

Middlesex Hospital Medical School,
London W1

- ¹ Ward, M., *Mountain Medicine*. London, Crosby Lockwood Staples, 1975.
- ² Smythe, F. S., in *Everest*, 1933, ed H. Rutledge. London, Hodder and Stoughton, 1934.

Heart block and autoimmunity

SIR,—In reply to Dr F I Lee (29 November, p 524) the four patients quoted in our paper who had chronic heart block and hypothyroidism did not develop these disorders simultaneously. In three patients heart block occurred between four and eight years after they had become clinically hypothyroid, while they were on replacement therapy. The fourth patient, whose history was quoted, was clinically euthyroid when heart block developed, but a raised thyroid stimulating hormone level at this time, together with evidence of multiple autoimmune disorders, led to the institution of thyroid replacement therapy, which has not, after 12 months, reversed his conduction disturbance. None of these patients had evidence of ischaemic heart disease but all had thyroid autoantibodies present. As in Dr Lee's case, the irreversibility of heart block by administered thyroid hormone suggests that a direct metabolic effect alone is insufficient to explain these data.

Permanent damage to the sinoatrial node has been reported in thyrotoxicosis,¹ and recently "lone" atrial fibrillation has been associated both with "silent" thyrotoxicosis and, surprisingly, with early hypothyroidism.² An autoimmune aetiology seems to be a possible unifying factor to explain these observations, and it is possible that circulating immune complexes, which have been proposed as a cause of the skeletal muscle damage in thyrotoxic ocular myositis,³ could be one of the mechanisms by which the heart is damaged in these autoimmune disorders.

A J FAIRFAX
A LEATHAM

Department of Cardiology,
St George's Hospital,
London SW1

- ¹ Wan, S. H., Lee, G. S., and Toh, C. C. S., *British Heart Journal*, 1972, **34**, 942.
- ² Myers, A. et al., *Abstracts of the British Cardiac Society Autumn Meeting*, 1975, p 20.
- ³ Konishi, J., Herman, M. M., and Kriss, J. P., *Endocrinology*, 1974, **95**, 434.

First-aid treatment of poisoning

SIR,—Your issue of the 29 November contained two items on this topic, a letter on "Salt overdose" (p 517) and the leading article on "Childhood poisoning: prevention and first-aid management" (p 483). On the first item we informed you in 1974 (9 November, p 342) that the joint manual of the voluntary aid societies would be modified

to omit the use by first-aiders of the induction of emesis in the treatment of swallowed poisons; this has now been done.

At the time we decided to make this modification we considered recommending the use of ipecacuanha in the first-aid treatment of childhood poisoning. We concluded that to try to define for first-aiders the indications for this procedure would lead to confusion and that the occasions on which first-aiders would be required to administer ipecacuanha were so few that it would be wasteful of resources and contrary to the aim of simplicity in first-aid equipment to provide it.

ANDREW RAFFLE
Chief Medical Officer,
St John Ambulance Association

JOHN GRAY
CMO, British Red Cross Society

HECTOR R F MACDONALD
CMO, St Andrews Ambulance Association

Chronic peritoneal dialysis for diabetic nephropathy

SIR,—Your leading article (16 August, p 397) entitled "Renal transplantation in diabetes," concludes that renal transplantation is probably the most promising treatment for patients with end-stage diabetic kidney disease. Renal transplantation may be the preferred treatment in younger diabetic patients. The mean age of those transplanted in Minneapolis was 34 years, the oldest patient being 49.¹ Success is more likely in those lacking severe cardiovascular disease and other complications of diabetes and in circumstances where a living donor is available. However, such patients make up only a small fraction of the total number of patients with end-stage uraemia due to diabetic nephropathy.

In the United States, with the recent enactment of new social security Medicare laws, renal replacement therapy is becoming feasible for nearly all patients with end-stage renal disease. The magnitude of the problem is great. It was conservatively estimated that in the US approximately 15 diabetic patients develop end-stage nephropathy per million population per year (3200/year in the US).² Many of these patients are in the older age group and have multiple complications of diabetes. For this group of patients transplantation is not feasible. The difficult medical and moral problem has been whether these patients are best treated by dialysis or by "conservative measures," which implies that they will soon die as the consequence of the disease. The results of dialysis therapy in this group often prove less satisfactory than in non-diabetic uraemic patients, but an increasing number of dialysis centres are accepting these patients for care. Although the results of haemodialysis in this population have for the most part not been good, maintenance peritoneal dialysis may offer a promising alternative in the patient with diabetes and end-stage uraemia.^{3,4} The mean age of the eight diabetic patients we have treated with maintenance peritoneal dialysis at this centre is 54 years. This mode of therapy may be better suited for the patient with severe cardiovascular disease who is prone to haemodynamic instability and arrhythmias. Since rapid fluctuations of blood pressure

are less frequent and systemic anticoagulation is not employed eye disease may not progress at as rapid a rate with haemodialysis, while problems of vascular access necessary for haemodialysis are obviated.

None of the current methods available for managing end-stage uraemia in diabetic patients provide the chances for rehabilitation seen in the uraemic patient without diabetes. In the older diabetic patient with severe cardiovascular disease it is likely that the physician, the patient, and the patient's family must accept more limited goals. Under such circumstances peritoneal dialysis may offer certain advantages over haemodialysis: it can be safely carried out at home even without the presence of another person, and a patient can be trained for self-care at home in less time than is required for haemodialysis. Thus a well-motivated patient may achieve satisfactory rehabilitation while peritoneal dialysis is performed during sleep three to five nights per week.

M J BLUMENKRANTZ
J E BAILEY
M YARON
J W COBURN

Medical Service,
VA Wadsworth Hospital Center, and
Department of Medicine,
UCLA School of Medicine,
Los Angeles, California

- ¹ Kjellstrand, C. M., et al., *Kidney International*, 1974, **6**, suppl. p 15.
- ² Knowles, H. C., *Kidney International*, 1974, **6**, suppl. p 2.
- ³ Jones, K. M., and Ivanovich, P., *American Society of Extracorporeal Technology Proceedings*, 1974, **2**, 97.
- ⁴ Blumenkrantz, M. J., et al., *Kidney International*, 1974, **6**, suppl. p 108.

Immunisation against whooping cough

SIR,—During the past year you have published several reports and letters about whooping cough, including notably the report of the Joint Committee on Vaccination and Immunisation (20 September, p 687). None of these publications offered data for epidemiological analysis, so readers were dependent for guidance upon the recommendations of the committee and of your leading article (25 October, p 186). In this article you referred to "evidence" that current vaccines give such a high degree of protection that experts are "almost unanimous" in recommending its use routinely, thus endorsing the view of the committee that the decline in the incidence of whooping cough since 1958 is attributable to immunisation.

Immediately after reading this leading article I sent to you a short paper, based largely upon data available to the committee, in which I questioned the assumption that routine immunisation was responsible for the decline in the incidence of whooping cough. I drew attention also to the continuing importance of overcrowding and other socioeconomic factors which appeared, in the UK generally and in Glasgow especially, to be at least as important as lack of immunisation in determining the distribution of recent outbreaks. So that the "evidence" could be assessed independently I stated that the raw data, national and local, on which my conclusions were based would be made available to anyone who wanted it through the Communicable Diseases (Scotland) Unit at Ruchill Hospital, Glasgow G20.