

### Other Virtues of Bran

SIR,—Mr. N. S. Painter and colleagues' article (15 April, p. 137) prompts me to write about the possible use of rice bran in the treatment of duodenal ulcer. It has been suggested<sup>1</sup> that the marked difference between the low incidence areas of duodenal ulceration in North India and the high incidence areas of South India may be related to the fact that the staple diet of these areas in North India is unrefined wheat and in South India is polished rice which has lost most, or all, of its bran content. Cleave<sup>2</sup> reported that the addition of rice bran to the diet of polished rice in prisoner-of-war camps in Malaya, and the change from polished rice in Hongkong to unrefined "Korea mixture" when prisoners were transferred to Japan, led to a remission in many duodenal ulcer patients. Glatzel<sup>3</sup> drew attention to a similar sequence in German soldiers at Stalingrad when unrefined grain and root vegetables were eaten in place of refined carbohydrates.

Two studies were conducted from the Holdsworth Memorial Hospital, Mysore, South India, of the effect of rice bran added to polished rice on the symptoms of patients suffering from duodenal ulcer. In one study 45 patients on two tea estates, who had had persistent pain and tenderness without more than a few days' remission for over two to three years, were given a daily issue of 40 g of pasteurized rice bran to mix with their cooked, polished rice for three months. Twenty were completely relieved and six were partly relieved of their pain. Two had temporary relief for the first few weeks. Likewise, 13 out of 24 outpatients with chronic duodenal ulcer and persistent pain went into remission when given rice bran. The rice bran had to be pasteurized to inactivate its lipase content and prevent it from going rancid.

An earlier report of one of these studies has been published,<sup>4</sup> and the other two studies described in greater detail elsewhere.<sup>5</sup> The trials were not controlled trials and not conclusive, but the findings suggest that this use of rice bran merits further investigation.—I am, etc.,

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1 Varma, R. A., in *After Vagotomy*, ed. J. A. Williams and A. G. Cox, p. 382. London, Butterworths, 1969.

2 Cleave, T. L., *Peptic Ulcer*. Bristol, John Wright, 1962.

3 Glatzel, H., *Arztliche Wochenschrift*, 1952, 7, 1064, and 1081.

4 Cleave, T. L., Campbell, G. D., and Painter, N. S., *Diabetes, Coronary Thrombosis and the Saccharine Disease*, p. 110. Bristol, John Wright, 1969.

5 Tovey, F. I., *Journal of the Christian Medical Association of India*, 1972, in press.

### Payment by Colour

SIR,—I have followed the recent correspondence on "Payment by Colour" with great interest. My wife and I came to Britain about two years ago, having practised as general practitioners in the African township of Soweto and in Fordsburg, a mixed residential area which is now being unscrambled. We lived in Fordsburg and served and practised among all groups and races, including the urbanized Afrikaners around us. For what it is worth I should add that because of our vocal opposition to the in-

justices of the apartheid system, which dehumanizes both the oppressor and the oppressed, we were restricted under the banning orders by a South African Government edict. My practice in Soweto was closed down, and after seven years of trying to work, live, and raise a family under restrictions we emigrated.

I feel I can answer Dr. J. K. McKechnie's question (29 April, p. 291) about non-white doctors' views with some authority. There is little doubt that the majority would prefer to see some form of sanctions, whatever they may say privately to their white colleagues. A reading of the South African scene will provide ample evidence for this attitude. To disregard the coloured boycott of Dame Margot Fonteyn and the reaction to segregated sport is only to swallow the official hand-outs by the South African Government.

Dr. McKechnie makes a special plea for mission hospitals, which I feel one might support as they are in a special position. The majority of the *B.M.J.*'s advertisements, however, are for teaching and government hospital posts, which are restricted to white doctors. One only asks that these should state the facts about race discrimination in selection and pay.

One other point should be stressed. Dr. McKechnie refers to the severe shortage of doctors. This applies only to black areas. For white South Africans there is one doctor to every 455 people compared to one to 100,000 for blacks. Redistribution of the country's medical resources would promptly relieve the problem.

Finally, it may be argued that South Africa should be encouraged to provide more black doctors. At present its output is 10 or 11 per year. If the country insists on failing to educate and use four-fifths of its population, it should not be entitled to plead for more medical help from abroad. In fact, if it were not able to depend on a steady flow of doctors and other skilled workers from outside, South Africa might be obliged to provide proper training and educative facilities for its non-white people.

Dr. McKechnie is known to me by repute and the work he is doing earns my admiration. Too few South African doctors are willing to undertake rural practice, and hardly any are prepared to protest strongly about the conditions that have led to such inequality of services.—I am, etc.,

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### Journals Galore

SIR,—May I answer Dr. P. M. O'Donnell (6 May, p. 354) and remind him of many more journals he has not even mentioned in his letter (the specialist *B.M.J.* publications, *Scottish Medical Journal*, and other local journals, *Postgraduate Medical Journal*, and journals from abroad including journals of the W.H.O.) any of which one may subscribe to—and many others. And I say the more the merrier, allowing more contributors to write for the good of us all and for medicine and for world health.

We have freedom of choice in what we read (or do not read) and are well able to discriminate and add to our knowledge by reading widely, whatever be our interest—

purely clinical or fringe material of the medical newspaper type. So I say, let the journals roll.—I am, etc.,

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### New Consultant Contract

SIR,—During recent local discussion we have been given details concerning a new contract for consultants which the Central Committee for Hospital Medical Services are seeking to negotiate. I would like to suggest that the proposed new contract would be unjust to many of the present whole time consultants, and also might ultimately endanger the continuation of private consultant practice within the N.H.S. The important new principle which the new contract seeks to establish is the abolition of the distinction between whole time consultants and those who work maximum part time. In future whole time consultants and those who now work maximum part time would work a ten-session week, and all consultants would have the right to private practice.

In our local discussions there was general agreement that the proposed new contract would have the effect of reducing the amount of future salary awards by the Review Body. The Review Body would be bound to take into account the fact that all consultants would have the right to augment their incomes from private practice. For part time consultants there would be compensation for this, arising from the additional sessional pay they would receive, but for those of the present whole time consultants who did not wish to exercise their new rights to engage in private practice, or who, from the nature of their specialty, could not easily do so, there would be a fall in future income prospects. There would arise under the new contract a pay differential between clinical and non-clinical consultants, and one point of view put forward in our local discussions was that it was desirable that this should happen. Clinical consultants carried greater responsibilities, worked harder, and put in longer hours. This should be acknowledged in the pay structure.

Should the new contract be adopted, consultants at present working whole time would be likely to find, when the Review Body next made an award, that the sum they would receive had suffered a downward adjustment on the basis that they were now working part time on ten-elevenths, compared with the present whole time contract of eleven sessions. This reduction of salary prospect would be particularly unjust to those whole time consultants who are now within five to seven years of retirement. Superannuation pensions are, of course, calculated on the average salary received during the last three years of service and the proposed new contract might reduce the pensions of whole time consultants by about one-eleventh of what they might expect to receive if the existing contracts continued. Because of the short time available, even those whole time consultants who are in clinical specialties could not expect to compensate fully for this loss of pension by exercising their new right to engage in private practice. In the past when a consultant on his appointment elected to be whole time, rather than maximum part time,