multifactorial causation then it is arguably the case that no single specialist is equipped with all the skills or resources required to effect adequate physical and psychological assessment, which may well be necessary in almost every case if the number of failed attempts at therapy is to be minimised. However, multidisciplinary approaches to health care and the facility of cross-referral could help to ensure that the patient receives appropriate assistance.

It is on these bases that we hold the view that any therapists engaging in the provision of help for sexually dysfunctional patients should be aware of the possibility that physical, pharmacological, and psychological factors, as well as others, may contribute to the onset and maintenance of the problems presented. Sex therapists should have access to facilities which will ensure adequate pre-treatment assessment and multidisciplinary therapy if appropriate. These views have clear implications for resource planning and the training of therapists, and we feel strongly that there are dangers in the currently popular concept of brief training in specific techniques to produce practitioners with skills limited to the treatment of discrete sexual dysfunction. The variety of settings outside the health services in which sexual problems may also be presented is of particular relevance to the question of adequacy of assessment, and there are implications for the wider availability to varied referral sources of health care facilities for the treatment of sexual dysfunction.

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Out-of-hours calls in general practice

SIR,—Both Dr B T Williams and his colleagues (7 August, p 368) and Dr M G F Crowe and his colleagues (26 June, p 1582) give us examples of the way out-of-hours care is provided, but they state that we do not know quantitatively what happens in large areas of the country. I can confirm that this was so when, in January 1975, I examined several features of group practices, including out-of-hours arrangements, throughout the county of Wiltshire.¹

Questionnaires were returned by 45 out of the 53 partnerships. This is a rural area and only two practices used a deputising service at any time. Of the 45 respondents, a duty doctor gave weekend cover in 44 evening cover in 42, and that partner also took emergencies after 10.30 am in 25 practices. Interestingly, in five instances the duty partner for the evening handed back the responsibility of each doctor for his own list at 11 pm. In nine practices the individual partners remained on call for their own obstetric cases at all times.

This survey was made primarily to examine the extent to which partners care for the patients on their own lists and it revealed that this was generally true for 12 practices (27%), whereas in the remainder patients attended any doctor. Those partners giving personal care to their lists during the day were just as likely to hand over to a duty doctor out of hours but were usually responsible for their own emergencies and late visits until evening surgery.

Your correspondents state that we know little about the acceptability to the public of the various methods of giving out-of-hours care. There is, surely, ample evidence that patients prefer to see a doctor whom they know rather than a complete stranger. Whether this is more effective care is much more difficult to establish except that a service given by doctors with little or no experience of general practice must have disadvantages.

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¹ Aylett, M J, *Journal of the Royal College of General Practitioners*, 1976, 26, 47.

Marital urinary infection

SIR,—Sexual intercourse is a well-recognised cause of urinary tract infection (UTI) in women but has not been incriminated in men. Experience in this hospital over the past 2½ years suggests that it is equally relevant.

Five married men aged 21 to 34 years presented with UTI due to *Escherichia coli* between 2 and 8 weeks after their wives had dysuria. Mid-stream specimens were obtained from four wives and showed *E coli* ($>10^5$ /ml) in three, of whom two were pregnant. Sexual intercourse had occurred in the week preceding the husband's illness. Another man presented with epididymitis and *E coli* bacteriuria 2 weeks after his wife had UTI due to *E coli*.

Serotyping of organisms is desirable to confirm this hypothesis, but the evidence is suggestive. It is of interest that one of the five men was found to have a shrunken kidney and vesico-ureteric reflux. The next time his wife has a UTI perhaps he should be given prophylactic chemotherapy.

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Alpha-fetoprotein and amoebic liver abscess

SIR,—Dr E P Gétaz (8 March 1975, p 573) reports the occurrence of a positive test for α -fetoprotein (AFP) in the serum of a patient with a proved amoebic liver abscess. A similar case has been seen in Ibadan, Nigeria.¹

A mass in the liver is a common diagnostic problem in northern Nigeria and in our hospitals we rely heavily on the results of serum AFP tests for the diagnosis of hepatoma. A positive test in a patient with a clinical picture strongly suggesting a malignant liver tumour is usually considered sufficient to establish the diagnosis of hepatoma. Serum AFP-negative patients are admitted to hospital for liver biopsy and further investigation. This policy spares many patients with hepatoma hospital admission and a potentially hazardous investigation. However, it is sometimes difficult by clinical signs alone to differentiate between an amoebic liver abscess and a hepatoma. If a positive serum AFP was a common feature of amoebic liver abscess our policy might lead us to make the serious mistake of diagnosing an amoebic liver abscess as a hepatoma. We have therefore reviewed the serological findings in patients with amoebic liver abscess seen by us during the past four years.

Fifty-three patients with an amoebic liver abscess were seen at Ahmadu Bello University

Teaching Hospitals at Zaria and Kaduna, Nigeria, during the period January 1972–May 1976. Diagnosis of an amoebic liver abscess was based on a suggestive clinical picture accompanied by a positive test for amoebic precipitins. In many patients confirmatory evidence was obtained by liver aspiration or by a response to treatment with metronidazole. Serum from 45 of these patients was tested for AFP by counter-current immunoelectrophoresis with a locally prepared rabbit antiserum. All were negative. With the same technique sera from 80% of cases of hepatoma are positive.

Although a positive AFP test can occur in patients with an amoebic liver abscess our findings suggest that it is very unusual. All our serum samples were collected at the time that the patient presented at hospital. Perhaps positive tests would have been found at a later stage of the illness when hepatic regeneration was occurring. We believe that our policy of not fully investigating all suspected hepatoma patients with a positive serum AFP is still justified provided that patients with any suspicious feature are further investigated. These investigations should include amoebic serology and, perhaps, a trial of metronidazole.

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¹ O'Connor, G T, *et al*, *Cancer*, 1970, 25, 1091.

Oral irritation with gentian violet

SIR,—In the past six months we have used gentian (crystal) violet to treat six neonates with oral candidiasis. All six babies developed oral ulceration, in one case within 24 hours. This resolved with cessation of therapy. Only those who received gentian violet developed ulcers; hence candidiasis per se was not the cause. A 0.5 or 1% aqueous solution of gentian violet was used and the manufacturers confirm the absence of additives. Applications were made twice daily. In all suspected cases *Candida* sp was cultured which was sensitive in vitro to nystatin, and only when this was clinically ineffective was gentian violet substituted.

We agree with John¹ that gentian violet is a potential irritant, but even complying with his dosage recommendations it is possible to produce ulceration. Increased mucosal sensitivity was a possible factor in our cases.

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¹ John, R W, *British Medical Journal*, 1968, 1, 157.

Platelet and coagulation studies in patients treated with bromocriptine

SIR,—We were interested to read the letter from Dr A D B Harrower and others (10 July 1976, p 109). After the initial report by Karmali and Horrobin¹ on the shortening of the bleeding

time in mice treated with bromocriptine we also started a study on the effect of this drug on platelets, coagulation, and fibrinolysis in man.

Ten patients with Parkinson's disease (6 male, 4 female) were given bromocriptine because they had become unresponsive to levodopa. The dosage was started at 5 mg daily and increased every three days by 5 mg up to 20-25 mg, according to the tolerance. It is too early yet to publish the effect on Parkinson's disease. Haematological studies were performed on each patient the day before the start of treatment and 15 days later (when they were taking 20-25 mg per day). The following tests were done: bleeding time (Duke's and Ivy's methods), platelet count, thromboplastin time, partial thromboplastin time, euglobulin lysis time, and platelet aggregation with ADP (0.33-0.66-1.09-1.66 $\mu\text{mol/l}$), adrenaline (0.82-4.10-41 $\mu\text{mol/l}$), and collagen at different dilutions.

No significant modification was observed in any of these measurements. In particular, it is to be noted that no enhancement of platelet aggregation was detected, even at low concentrations of aggregating agents.

Our results show that patients with Parkinsonism can take a clinically effective dose of bromocriptine without any change in platelets, coagulation, or fibrinolysis, even at doses twice as high as those used by Dr Harrower and his colleagues.

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¹ Karmali, R. A. and Horrobin, D. F., *British Medical Journal*, 1975, 3, 307.

Atmospheric pollution by anaesthetic agents

SIR,—The agitation about the effects (if any) on theatre personnel of atmospheric pollution by anaesthetic gases has at last produced a DHSS circular calling for action by regional and area health authorities to install scavenging systems.

The Department admits that it is in no position to lay down standards, nor can it define the hazards with any precision. The circular does agree there is a need for further research. Possibly an answer to this problem could be found by investigating the history of those who work in the dry-cleaning industry, many of whom are obviously exposed to concentrations of commercial trichlorethylene a good deal higher than those encountered in hospital practice.

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Hazards of smallpox vaccination

SIR,—In Sir James Howie's article on communicable diseases (24 July, p 217) he remarks that smallpox is definitely on the way out and

that routine vaccination carries more hazard than the disease. This optimistic view, however, overlooks an important point, which is that until the disease has completely disappeared many countries will insist on vaccination of persons entering from other countries, and vaccination will then be necessary as an adult. This is a much more unpleasant and a more hazardous event than vaccination in childhood.

Since many of our citizens travel abroad, and since there is a large social interchange between this country and areas where the disease is still endemic, travellers from these shores are more likely than most to need vaccination for travel purposes. It would therefore seem that abolishing vaccination in early life is not yet justified until the last traces of the disease have been eradicated in the endemic centres.

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United profession

SIR,—Sir George Godber (31 July, p 303) calls for some new body to represent the profession's views on "greater interests," inferring that remuneration is a lesser interest. Dr John Fry (14 August, p 425) suggests that the new-model GMC might fulfil this function.

It is perhaps easy for a senior civil servant secure in his gold-plated salary, even easier when retired on his inflation-proof pension, to decry financially motivated "union-style" activities. But to most of the profession, especially the younger and less secure, the rate for the job is of great importance and cannot be divorced from plans affecting the job itself. I believe that most of our present troubles have been caused by politicians and bureaucrats insisting on discussing new work and fresh commitments apart from remuneration, such sordid difficulties being swept aside and referred to the once independent and now virtually defunct Review Body. I would therefore hope that in future work and pay will be more closely linked in "union-style" negotiations at all levels.

I do not consider the GMC with Government nominees and non-elected members, a suitable body to represent the profession in these matters: its prime duty is quite properly to protect the public. The BMA would appear to be the obvious organisation to represent all doctors on all such matters. It exists, it has premises, funds, staff, and experience. That is not to say that it is perfect or even satisfactory in the eyes of all the profession. But surely the answer is for all of us, senior and junior, salaried and independent, specialist and generalist, to join, to subscribe, to attend meetings, to vote, and to mould the Association and its policies into the shape the profession wants. After all, unless we are all prepared to do all these things no organisation, whatever its name or aims, can hope to represent us effectively.

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SIR,—The letters from Sir George Godber (31 July, p 303) and Dr John Fry (14 August, p 425) reiterate the dwindling unity in the profession, but the solutions they offer lack the urgency which the problem demands.

Since the inception of the NHS (which was introduced in toto overnight on 5 July 1948) there has been too much drift and not enough constructive progress. It may well be that the profession is partly responsible for this, but so to a large degree have been the various governments concerned. One has sometimes been forced to the conclusion that a government would find it easier to achieve some of its purposes if it had to deal with a divided profession. The doctors have often been faced with frustration with regard to pay, conditions of service, equipment, buildings, etc. Yet at no stage has there been a firm political announcement that certain aspects of health care were incapable of fulfilment or that there must be some limitations for certain sections of the community. Until recent years it seemed obvious that a great deal of good will and long working hours were being given not only by the doctors but by all who worked in the Health Service. Now this seems to be running out.

Against this background of discontent it is little wonder that alienation between the various professional interests should occur. In this unhappy aura some doctors have turned away from the BMA and formed their own outside associations. The situation demands urgent attention before it becomes worse. A close look at the work of the BMA in relation to the Health Service will reveal that in the circumstances it has achieved a good deal for both the patient and the doctor. There is no time to wait for the formation of an institute of medicine or a reconstituted GMC. The BMA should call an urgent meeting of all sectional interests of the profession, including all break-away associations, with a view to uniting them before a deteriorating service becomes still more mediocre. Arising out of this unity could come constructive proposals outlining the way the Health Service should progress.

GEORGE S R LITTLE

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SIR,—The current fad for a trade union solution to the problems of the NHS has been voiced again by Dr John Fry (14 August, p 425). Surely it is self-evident that trade unionism cannot improve the standard of living of members except at the expense of other groups. A better living standard can come only from systems which promote the production of wealth, and trade unions by their nature must promote inefficiency or be untrue to their less efficient members. It is indeed trade unionism which creates the splintering which Dr Fry abhors. The rise of so-called trade union power in the last 12 years has been associated with accelerating national economic decline, only partly masked by inflation and massive borrowing.

The NHS has not moved from bad to worse because of any lack of sincerity, intelligence, or sound motivation in those colleagues who have undertaken the thankless task of so-called negotiation. The problem remains exclusively in the economic structure built into the NHS by the ignorance of its founders. Firstly, by total State financing the Service must be paid for by a fixed sum year in year out without regard to changing fashions or technological advances. This guarantees that more money in one area must come by transfer from