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Letter from . . . Canada

The phantom crossroads

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The acknowledged British genius for compromise is always in danger of degenerating into an attempt to have cake and to eat it at the same time. Dismally bewailing the loss of professional independence within the National Health Service, while at the same time extolling its virtues and enjoying its benefits, is an excellent example of this exercise.

A national health service as opposed to national health insurance is bound to have the advantages of security and the disadvantages of central control. Doctors cannot have it both ways.

Future of professional independence

The observer could not fail to be fascinated by the contrasts offered at the recent tripartite meeting of the BMA, CMA, and IMA in Dublin. Both British and Canadian speakers repeatedly voiced their concern about the future of professional independence. But the viewpoint, the philosophy, and the style were quite different. The British seniors, like so many well-groomed gannets, each with his own niche on the monolith of the National Health Service, comfortably ensconced on his merit award, and

ignoring the humble puffins at his feet, nictitated in mild disapproval at the raucous, disorderly flock of egalitarian Canadian gulls. The Canadians, guardedly satisfied with their comprehensive scheme developed in partnership with government, but fully aware of its faults, while discussing their efforts to control abuse, rather ingenuously exhibited only its seamier side. They were then quite taken aback by moralistic attacks on their method of charging fees only for service rendered; especially when these attacks issued from British colleagues, who, while enjoying the excellent Hibernian hospitality, were also drawing full pay. Their juniors were doing the work at home. Yet in the next breath these urbane and supremely competent men were bewailing their loss of freedom. The profession can't have it both ways. A disciplined hierarchy means control from above. A non-rigid system of piecework means some will try to abuse it. Both mean working with government, but in case of disagreement the Canadian doctor can opt out and bill his patient. After 25 years of salary and sessional and capitation payment the British feel that this is somehow "not quite cricket."

A common contemporary oratorical posture among the medical politicians of old Albion is to stand looking into the middle distance, the right arm extended and the left hand clasped over the heart while proclaiming: "British medicine is at the crossroads." Nonsense. There has been no crossroad since 1946, for the very good reason that a crossroads means that there is a viable alternative route available to the profession and, far more important, available to the patients. Since that date British medicine has been on the broad high-road towards a full-time salaried state service. Now rearguard action is becoming increasingly difficult without resorting to a withdrawal of services,

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which hurts the patients and violates the ethics of all good doctors. To provide a true crossroads, now that so many are wedded to the primrose path, will take a great deal more than oratory.

A viable format

Firstly, the planners, the economists, the actuaries, and the lawyers have to sit down with the doctors and devise a new format, shorn of expensive bureaucracy, which is more efficient, competitive, and, in the long run, cheaper. This then has to be sold up-hill to those who will fear losing their mess of pottage in any transition, and this would obviously mean many of the senior doctors approaching pensionable age. Adequate provision for full-time academics and research workers has to be worked out. At the same time the public has to be convinced that the new system would be a better method of providing

medical care. Supervised competition means good and prompt service. The patient is much more in control than the civil servant administrators. The public also have to be shown that those in true need would be adequately subsidised.

Finally, and perhaps most difficult of all, the profession must be convinced to unite behind the idea of such an organised system of national health insurance and behind one organisation as their leader and spokesman. Should these steps be achieved, the politicians will follow.

The work involved, the amount of persuasion needed, the quality of leadership demanded are obviously far greater when one has to change the direction of a system already well entrenched than if one is building anew. Whether the British profession wish to consider this or to pursue their present course is nothing to do with a Canadian commentator, but only when such a viable alternative is hammered into shape and is available to most of the British public will the medical profession truly be at the crossroads.

Today's Treatment

Diseases of the alimentary system

Acute diarrhoea in adults

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The treatment of diarrhoea includes three major elements: symptomatic, supportive, and specific. Specific treatment will depend on an accurate aetiological diagnosis, and it is only realistic to accept that in most brief episodes of diarrhoea the cause is not found. For this reason symptomatic and supportive treatment are especially important—all the more because most acute episodes of diarrhoea are self-limiting, and the patient will have recovered before rational specific treatment based on a correct diagnosis can be started.

Symptomatic treatment

Symptomatic treatment aims to stop the diarrhoea or at least reduce its severity. The traditional remedies are kaolin mixture and chalk mixture. Although they are often said to absorb "toxins" from the gut, there is little evidence to support this. The morphine present in the chalk and opium mixture and kaolin and morphine mixture acts only via the bloodstream after being absorbed from the bowel, and not by a local effect on the gut wall. As the kaolin and morphine mixture contains only 0.7 mg of morphine in 10 ml, the amount of morphine in normal

doses is therapeutically unimportant. Chalk and opium mixture contains 5 mg of morphine in 10 ml and a small but useful pharmacological effect might result from the opium absorbed.

Codeine is of little use in controlling acute diarrhoea, but it has a place in the symptomatic treatment of chronic diarrhoea. An adult dose of up to 60 mg four-hourly may then be used.

Morphine by injection produces good symptomatic relief in acute diarrhoea associated with pain, but its use should be confined to patients with severe symptoms, such as in severe bacillary dysentery. It is usually unnecessary to give more than two or three doses. Because it may be habit forming it has no part to play in treating chronic diarrhoea.

Diphenoxylate with atropine (Lomotil) is popular nowadays, especially for keeping the patient with mild diarrhoea of short duration ambulant. The dose is two to three tablets (each contains 2.5 mg diphenoxylate) immediately, then one to two tablets six-hourly. The drug depresses the central nervous system and should not be given at the same time as other sedatives; it can potentiate the effects of alcohol dramatically. Because of its depressant effects it is no longer recommended for children. It should not be given for more than five days and has no place in prophylaxis. The side effects of diphenoxylate—mainly drowsiness, dizziness, depression, and nausea—may be troublesome. The drug is related to morphine, so that long-term administration may cause habituation. Over-dosage may cause coma and respiratory depression, reversible by nalorphine. A dose of only six tablets in a 2-year-old child led to coma and respiratory and cardiac arrest, so that patients given the drug must be told of the importance of keeping it away from children. Diphenoxylate is contraindicated if liver disease is present.

Hydrophilic substances given by mouth will absorb water from a liquid stool and themselves swell and add body to the faeces.

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