

seems sensible that such a language should be developed between sociologists and consenting conversational partners, and at least Mr Chester and his colleagues have established that certain marital practices such as masturbation and faking orgasm are widespread, and the dissemination of their findings will help many women to realise that what they do is normal and not a shameful personal idiosyncrasy.

The session devoted to minority groups looked at new attitudes to sex in the mentally handicapped. Dr Michael Craft and his wife were able to give a blend of statistics and case histories which indicated that changes in attitude of the staff in mental handicapped hospitals are now permitting the development of loving relationships and even marriage among their patients. Many difficult problems remain, but a gradual and moderate approach is welcome in an age when so many pioneering movements are based on an ideology of band-wagon permissiveness. The Crafts' efforts clearly spring from compassion and an understanding of the needs and feelings of the mentally handicapped and of those whose difficult task it is to look after them.

The proceedings of the symposium will be published by the Academic Press next summer. The topic for next year's symposium is "Changing Patterns of Conception and Fertility" and that for the following year is "Changing Patterns of Childrearing." Despite its outdated name, the Eugenics Society provides a forum in which doctors join with those of other professions and disciplines in a constructive and responsible approach to biosocial problems.

Problems with leishmaniasis

British physicians and dermatologists are becoming increasingly familiar with the patient who has returned from a Mediterranean or Central American holiday with a chronic sore that turns out to be due to cutaneous leishmaniasis. Visceral leishmaniasis is less commonly imported, but the case of a Finnish baby who contracted the disease after an exchange blood transfusion (one of the donors had been to the Mediterranean) is a reminder of its presence.¹

Classical epidemic visceral leishmaniasis has its home in the plains of the Ganges and Brahmaputra, where kala-azar would sweep through the valleys every 10 years. The protozoan parasite is transmitted from man to man by the highly anthropophilic sandfly *Phlebotomus argentipes*. These flies were virtually eliminated by DDT during the antimalarial programmes of the 1950s, and transmission stopped. But a reservoir of infection persisted in patients with post-kala-azar dermal leishmaniasis, and in the early 1960s Sen Gupta² warned that as antimalarial spraying ceased and the sandflies returned another epidemic could break out. This has now happened. In early 1975 cases of kala-azar were being reported in Bihar and Uttar Pradesh³—and in some adjacent states where the disease had not previously been considered endemic. The epidemic moved swiftly through the vast non-immune population. In 1977 an estimated 70 000-100 000 cases occurred in Bihar alone, with 4000 deaths.⁴ Accurate diagnosis has been hampered by lack of laboratory facilities and the confusion caused by the massive return of malaria to the area. The lack of leishmanicidal drugs, which were not produced in India, compounded the disaster. So far the Indian Government has established a kala-azar research unit in Patna, DDT spraying has been restarted, and three Indian pharmaceutical

companies have begun to manufacture sodium stibogluconate. But the disease is still not entirely under control. In other countries visceral leishmaniasis remains a disease mainly of canines or rodents, and human disease is usually sporadic. But local outbreaks may occur: one occurred in Northern Italy,⁵ for example, where for every case of classical disease there were about 30 subclinical infections.⁶

Cutaneous leishmaniasis is a serious obstacle to developing the vast forests in South and Central America. The infection is widespread among rodents, and most workers who enter the forest become infected. The resulting lesions may be chronic and disfiguring. But far worse are the metastatic mucocutaneous lesions of espundia (from the Portuguese for sponge) that mutilate the nose, mouth, pharynx, or larynx.⁷ The incidence of this complication after a primary skin lesion varies greatly, from 2% in Panama to 80% in Paraguay. Thanks to years of painstaking work by Lainson, Shaw, and their co-workers⁸ of the Wellcome Parasitology Unit at the Instituto Evandro Chagas, Belém, the reason for the variation has now become clear. They have put order into the epidemiological chaos in the forests and have shown that the two important parasites, *Leishmania mexicana* and *L. braziliensis*, represent complexes of several species, *L. b. braziliensis* being the main and possibly sole cause of espundia. *L. b. guyanensis* and *L. b. panamensis*, which are responsible for sores in large tracts of South and Central America, rarely cause espundia. Techniques of biochemical taxonomy developed by Gardner, Chance, and Peters in Liverpool have helped to solve the problem of distinguishing these parasites.⁹ The vector of *L. b. braziliensis* is *Psychodopygus wellcomei*, an anthropophilic fly that bites man viciously by day or night. Though this parasite may be patchily distributed through the forests, it presents a serious health risk. *L. m. mexicana* and *L. m. amazonensis*, which can cause the non-healing diffuse cutaneous leishmaniasis as well as simple sores, infect up to 20% of the forest rodents; but the vectors are not anthropophilic, so man is less readily infected unless, like the Mexican chiclero, he spends long hours in the forest disturbing the leafy floor.

American cutaneous leishmaniasis has proved difficult to contain. Complete control of the vectors could be achieved only by destroying the forest, and even this might bring to light new parasites. A vaccine seems the logical answer. Natural live vaccines have been used with success in the Middle East, but immunity is species specific, which would pose problems with species that cause espundia. Furthermore, the mechanisms of protective immunity in leishmaniasis are still poorly understood. Even so, a trial vaccine should be feasible.¹⁰ Alternatively, an insect repellent taken by mouth and excreted in sweat might provide a new approach to personal prophylaxis.

Treatment of leishmaniasis is also difficult. Sodium stibogluconate is not always effective, though most reported failures are probably due to inadequate dosage. Amphotericin B and pentamidine are seriously toxic. A recent innovation, still experimental but very promising, has been to incorporate antimony into liposomes. These are preferentially taken up by reticuloendothelial cells, and so reach the parasite at high concentration. In one experimental system this technique proved 200 times more effective than conventional treatment.¹¹

¹ Targett, G, unpublished information.

² Sen Gupta, P C, *Scientific Reports of the Instituto Superiore di Sanità*, 1962, **2**, 124.

³ Sen Gupta, P C, *Journal of the Indian Medical Association*, 1975, **65**, 89.

⁴ Peters, W, personal communication.

⁵ Pampiglione, S, La Placa, M, and Schlick, G, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1974, **68**, 349.

⁶ Pampiglione, S, et al, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1976, **70**, 62.

- ⁷ Marsden, P D, and Nonata, R R, *Revista da Sociedade Brasileira de Medicina Tropical*, 1975, **9**, 309.
- ⁸ Lainson, R, and Shaw, J J, *Nature*, 1978, **273**, parasitology suppl, p 595.
- ⁹ Chance, M L, Gardener, P J, and Peters, W, *Colloques Internationaux du CRNS*, 1977, **239**, 53.
- ¹⁰ Bryceson, A D M, in *Pathogenic Processes in Parasitic Infections*, ed A Taylor and R Müller, p 85. Oxford, Blackwell Scientific, 1975.
- ¹¹ Black, C D V, Watson, G L, and Ward, R J, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1977, **71**, 550.

Powars, Iros, et al

The BMA has been a registered trade union only since 1971.¹ Yet for most of this century the BMA, though a voluntary professional organisation, has functioned as a de facto trade union, democratically representing doctors at national level. Indeed, according to a recent sample poll of BMA members conducted by BUPA, 80% of the 1000 or so respondents put central negotiations as the most important function of the BMA.

With a full-time secretariat concentrated mainly in London and a local divisional network of voluntary officers the BMA has inevitably been a centralised organisation—some doctors might say overcentralised. The combination of local medical committees looking after GPs' "workplace" needs, the simplicity (until recently) of hospital doctors' contracts, and individual doctors' powerful influence in NHS hospitals meant that there was no great pressure for the BMA to strengthen its voluntary infrastructure. But times have changed, inside and outside the NHS, as the Representative Body overwhelmingly recognised at Cardiff this year when it approved a deceptively simple looking motion from Bedfordshire "that this meeting supports the early appointment of accredited workplace representatives."²

This resolution stemmed from the conclusions of Dr A A Clark's Working Party on the Functions and Priorities of the Association,³ which made a realistic assessment of what services the BMA should offer to its members in an age of variable individual contracts, complex trade union and employment legislation, and the growing local and national power of other NHS unions. The ARM made two other, complementary decisions. Firstly, that "the BMA should appoint in each region, as a matter of urgency, a member of staff with experience in employment legislation and industrial relations," and, secondly, "that this meeting would welcome more whole-time regional medical and non-medical BMA staff." There was no question that despite the high cost the Representative Body wanted these changes urgently. So the central BMA secretariat has written to divisional secretaries explaining the plans for action (14 October, p 1103).

The BMA has now appointed a senior industrial relations officer (21 October, p 1170), and some divisions have already nominated place of work accredited representatives. The aim

is to develop a nationwide network of POWARs, starting in the hospitals. It would be premature to define too rigidly what these new-style BMA representatives will do. As their main function will be to provide help in hospitals the way they work will undoubtedly evolve in response to members' local needs. But in some informal notes of guidance (p 1243) the BMA has sketched out the broad pattern of the POWARs' work. These workplace representatives—shop stewards in industrial parlance—will work in close co-operation with divisional secretaries and hospital doctors' representatives, caring for the needs of BMA members, as well as recruiting new ones. They will also be acting for the BMA locally in a trade union capacity, with expert support from industrial relations officers (full-time regional BMA staff who are to be introduced over the next year or so) and from provincial medical secretaries. NHS general practitioners are self-employed, so that initially they will not come within the ambit of the POWARs unless working part time in a hospital post. GP members of the BMA will, of course, be able to seek the advice of the IROs. POWARs will, however, appreciate the value of maintaining a good liaison with local medical committees.

While many people instinctively equate shop stewards with industrial action, this is an erroneous reflex: the shop steward's main job is helping individual members with their workplace problems. This will be the most important activity of the BMA's accredited representatives, but, in the unhappy event of the profession's contemplating militant action centrally, the POWARs will be responsible for organising it in their area, for only they, as official union representatives, will be protected in law when undertaking this function. All this is new territory for the medical profession. The NHS already puts a heavy administrative and advisory burden on doctors, so will a sufficient number of them be willing to take on yet more duties? After all, some divisions are even now hard pressed to attract active members. Perhaps the success of the Royal College of Nursing's stewardship scheme will encourage would-be volunteers. The RCN launched its stewards in 1972 and now has 2000 of them. Over the past 18 months or so, with the scheme in full working order, the college's membership—which, like the BMA's, is voluntary—has risen from 86 000 to 110 000. A proportionate surge in the BMA's membership would greatly strengthen its local and national negotiating powers.

Further "unionisation" of the profession will not please all doctors. In the "real politik" of today's unsettled NHS, however, doctors would be naive to gather their professional skirts about them and pretend no interest in the constant jockeying for power. The profession's ability to influence decisions in the Health Service is vital—not just for the doctors' good but in their patients' interests as well. POWARs, IROs, et al will enhance this influence.

¹ *Industrial Relations Act 1971*. London, HMSO, 1971.

² *British Medical Journal*, 1978, **2**, 301.

³ *British Medical Journal*, 1978, **1**, 1001.