

abdominal neurosis and lucrative for surgeons who fixed the dropped organs in their supposedly correct position). Other essays, reminiscent of Asher's *Talking Sense*, were "Mythical Maladies" and "Sins and Sorrows of the Colon"—a protest against the popular belief in purgatives and intestinal lavage. This approach, together with some physiological studies on the sensibility of the alimentary tract and his classic work on its motility by the bismuth meal x-ray examination, put gastroenterology on the map as a scientific subject. Later important contributions concerned achalasia, hiatus hernia, psychological aspects of dyspepsia, and megacolon.

Hurst died in 1944, and the story of his life<sup>2</sup> is the story of medicine in the first part of the 20th century, and will no doubt be discussed at the special centenary meeting organised by Dr Thomas Hunt to be held at the Royal College of Physicians of London on 23 July. Hurst had an international outlook and, at a time when medical travel was less common than today, visited many clinics abroad. His success in private practice was subordinated to hospital work, though this was then the consultant's sole income. He founded a gastroenterological club in 1935—the birth of the British Society of Gastroenterology. Neither asthma nor deafness deterred him; indeed, if attacked by breathlessness during a teaching round, he would inject himself with adrenaline in the ward sister's office and carry on. His conspicuous hearing apparatus was used intently in any lecture which he found interesting, but would be switched off if he found the speaker trite or uninspiring. He was always ready to accept changing concepts. When asked for reprints of his papers, he once wrote that they always seemed to be out of date.<sup>3</sup>

True or false is a formula that can be fairly applied to the works of anyone who has made original contributions; and, of course, Hurst was wrong in some things. So is everyone who produces new ideas. The way to avoid this is to go through a medical career immune to progress, averse to original thought, and hidebound with obsolete ideas learnt as a student.

<sup>1</sup> Thomas Hunt, ed, *Selected Writings of Sir Arthur Hurst*. London, British Medical Association for the British Society of Gastroenterology, 1970.

<sup>2</sup> Hurst, A F, *Essays and Addresses on Digestive and Nervous Diseases and on Addison's Anaemia and Asthma*. London, Heinemann, 1924.

<sup>3</sup> *A Twentieth Century Physician: Being the Reminiscences of Sir Arthur Hurst*. London, Arnold, 1949.

## Non-specific genital infection

The unsatisfactory diagnosis of non-specific genital infection is usually made when efficient routine microbiological techniques fail to identify any of the common genital pathogens in appropriate specimens. Clinically, most such cases present as non-gonococcal urethritis in men, but non-specific cervical and vaginal infections are also extremely common.

Among the 229 806 men attending venereal disease clinics as new patients in Britain in 1976 a non-specific genital infection was diagnosed in 32%; nearly all had non-gonococcal urethritis. Non-specific genital infection is now by far the most common of the sexually transmitted diseases, and, furthermore, its frequency has increased more rapidly than any other in the past 25 years. Willcox<sup>1</sup> has pointed out that many further cases of non-gonococcal urethritis are concealed under the diagnosis of gonorrhoea. After treatment of gonorrhoea with penicillin about half the men will be found to

have non-specific infection. While many of these will have symptoms and so receive treatment, their female partners are likely to be given treatment only for gonorrhoea.

The common presentation of non-gonococcal urethritis is with discharge, mild dysuria, and frequency. The discharge is usually slight and greyish, though on occasions it is profuse and frankly purulent. Sometimes the urethral secretion is so slight as to go unremarked by both patient and doctor, when the accompanying symptoms of dysuria and frequency may lead to extensive investigation. In such cases a few observant (and often introspective) patients may notice a urethral discharge—but only before the first micturition of the day. When there is a clinically significant infection a first specimen of urine will always show characteristic threads or a faint haze of pus, while subsequent specimens will be clear. Such findings always indicate a need for urethral smears and cultures to exclude subacute gonorrhoea.

Asymptomatic non-gonococcal urethritis is common: Rodin<sup>2</sup> found it in 12% of asymptomatic men attending a venereal disease clinic. Most patients with frank urethritis are referred to clinics because of the probability of gonorrhoea, but men with subacute symptoms are often treated by family doctors.<sup>3</sup> Among the reasons why non-specific genital infection and especially non-gonococcal urethritis are unsatisfactory diagnoses is the gap between theory and practice in their diagnosis. At least half of the episodes of non-gonococcal urethritis are due to infection with *Chlamydia trachomatis*; but, since appropriate cultural and serological tests are not generally available, precise diagnosis is rarely possible in an individual case.

Empirical antibiotic trials have shown good results in non-specific genital infections only with the tetracyclines and the macrolide antibiotics.<sup>4</sup> In vitro *C trachomatis* is sensitive to these drugs,<sup>5</sup> and clinical trials have confirmed that they are effective in treating urethritis associated with this agent, the clinical response coinciding with the disappearance of the organism from the urethra. The same drugs seem equally effective in cases of chlamydia-negative urethritis. Oriel *et al*<sup>6</sup> did note, however, that in a few cases the agent persisted in spite of a 14-day course of treatment (and reinfection seems an unlikely explanation), so that the cure rate is not 100%.

How then should non-specific genital infection be managed—at least in its most familiar clinical presentation as non-gonococcal urethritis? Treatment with oxytetracycline, 250 mg six hourly, or a triple tetracycline, 300 mg twice daily, should be continued for 14 days. Ideally consumption of milk products should cease during treatment, since they reduce absorption of these drugs, though not of doxycycline. Another alternative is erythromycin stearate. Side effects with these regimens are generally few. Female consorts should be examined and treated for any specific infections; in addition, consorts should always have a similar course of tetracyclines or erythromycin. During pregnancy or lactation only erythromycin should be used; in pregnancy some clinicians may prefer to postpone treatment until after delivery. The newborn child should then have close supervision. Sexual intercourse should be firmly banned while either partner is undergoing treatment and the reason explained—namely, the risk of reinfection. Banning alcohol is more controversial: even if the advice is actually taken the benefit is not clear.<sup>7</sup>

If symptoms persist, a further 10 days' treatment with the chosen antibiotic will often achieve a cure. If the female partner or partners have not been examined, the possibility of an underlying trichomonas infection should be considered. Even when attempts to identify trichomonads by urethral

scrape and culture have failed metronidazole, 400 mg twice daily for two to three days, should be tried.

Men treated for gonorrhoea should be carefully observed for two to three weeks afterwards in case non-gonococcal urethritis develops. Should it do so appropriate treatment should be given to both patient and consort. A drug that could be given in one or two doses, effective against both gonorrhoea and non-gonococcal urethritis, would be invaluable—provided that it was reasonably cheap.

The precise extent of the risk of pelvic inflammatory disease for female contacts is not yet clear, but *C trachomatis* was thought responsible for two-thirds of a series of 143 laparoscopically confirmed cases of pelvic inflammatory disease in Sweden.<sup>8</sup> A more obvious risk is that these women may infect other sexual partners, or their babies. If all female contacts could be given appropriate treatment, the reservoir of infection would be much reduced.

<sup>1</sup> Willcox, R R, *British Journal of Venereal Diseases*, 1979, **55**, 149.

<sup>2</sup> Rodin, P, *British Journal of Venereal Diseases*, 1971, **47**, 452.

<sup>3</sup> Fox, H, *British Journal of Venereal Diseases*, 1974, **50**, 125.

<sup>4</sup> Holmes, K K, Johnson, D W, and Floyd, T M, *Journal of the American Medical Association*, 1967, **202**, 474.

<sup>5</sup> Ridgway, G L, Owen, J M, and Oriel, J D, *Journal of Antimicrobial Chemotherapy*, 1976, **2**, 71.

<sup>6</sup> Oriel, J D, Ridgway, G L, and Tchamouroff, S, *Scottish Medical Journal*, 1977, **22**, 375.

<sup>7</sup> Arya, O P, et al, *British Journal of Venereal Diseases*, 1978, **54**, 414.

<sup>8</sup> Trehan, J D, et al, *British Journal of Venereal Diseases*, 1979, **55**, 26.

## Private uncertainty

Within six weeks of the Conservative Party's victory the new Minister of Health, Dr Gerard Vaughan, issued his "consultative document" on private practice in NHS and other hospitals (p 226). Many doctors may groan at the prospect of even more discussions, but Dr Vaughan does not ask whether changes should be made, simply "how" his proposals should be given effect. His letter, to which he wants replies by 31 July, outlines the Government's intentions to abolish the Health Services Board; to provide NHS pay-beds and facilities where needed; to give day-to-day control to AHAs, with the Secretary of State in an appellate and guiding role (assisted by an advisory committee), though ultimate power will still be his; to allow for private hospital developments (of a "significant" nature) to be agreed in consultation with the appropriate AHA—with the Secretary of State settling any disagreement; and to encourage increased collaboration at AHA level between the NHS and private sector (provision of services, staff training, and research).

This is an attempt to take private medicine some way back along the separated trail blazed by Barbara Castle. When she took over at the DHSS in 1974 her well-publicised view was that private practice had no place within the NHS and precious little outside it. She failed, through the Owen Working Party, to get doctors to agree with her, but, despite this, Mrs Castle pressed ahead with her plans,<sup>1</sup> publishing a "consultative document" in the summer of 1975.<sup>2</sup> Her twofold plan, launched with the impetus of much publicised anti-pay-bed militancy by some NHS trade union staff, included a rapid phasing out of all access for private patients to NHS hospital beds and facilities and tight political control of development of the private alternative sector. It produced an unprecedentedly united reaction<sup>3</sup> from the BMA, the BDA, the HCSA, the

royal colleges, the provident associations, and the Independent Hospital Group. Battle lines were drawn and, when even the announcement of the Royal Commission on the NHS<sup>4</sup> offered no respite, only Lord Goodman's intervention averted a major crisis.

Lord Goodman's plan, conditionally accepted by the Government, was announced in December 1975<sup>5</sup> and early in 1976 consultants accepted it after a ballot. In essence, the Goodman plan removed the future of private practice (in and out of the NHS) from the political control of the Secretary of State. "Phasing out" was to continue but under the control of a statutory Health Services Board and, in general, only as alternative hospitals and so on came into being. Private hospitals generally would be subject only to normal planning (and standards) control; but large new developments would require the authority of the board—which could be refused only if the board believed that the development would "significantly damage" the NHS, and for no other reason. The profession unenthusiastically accepted Lord Goodman's compromise, and the Health Services Board, comprising two doctors and two TUC nominees, with a legal chairman, has carried out its statutory duties at a measured pace—too slow for Labour politicians, too fast for most doctors.

So why has the new administration's promise virtually to repeal the Castle/Ennals legislation not drawn an enthusiastic response from the profession and only muted threats from the unions? Do doctors, administrators, and unions recognise the value of some buffer between the different factions and has the Health Services Board fulfilled this role? Or do they fear that the large numbers of AHAs, with their varying political composition, will inevitably produce widely differing interpretations of the rules, however much central guidance is given, which could make life uncertain both for consultants doing private work and for the independent hospitals? Furthermore, might some AHAs see themselves as competing with the private sector for staff, a fact which could well influence their decisions on introducing or developing non-NHS health facilities? These questions are bound to worry doctors, who, while generally welcoming the Conservative policy of devolving power from the DHSS (with less Whitehall "nannying"), may be less than happy with this particular application of it.

In an ideal world Nye Bevan's "geographical whole time" compromise for NHS consultants wanting to do some private practice is the best answer. Even in the present NHS it still remains the most sensible solution. But common sense is notably absent from this political issue, so that some consultants believe that the only reasonable assurance of the private alternative is outside the NHS—while keeping "Section 59" access (for the abnormal case) as long as possible. Thus, ironically, Dr Vaughan's well-intentioned liberation plans may do little more than throw the future of private medicine into confusion, for who will raise the hundreds of millions of pounds needed to develop non-NHS facilities if at any moment an AHA or the Secretary of State can cut the economic ground from under their feet by authorising more pay-beds? The ridiculously short time allowed by Dr Vaughan for consultation is a bad habit caught from his predecessors. He should give doctors time for adequate consultations so that a durable relationship between private medicine and the NHS can be worked out.

<sup>1</sup> *British Medical Journal*, 1975, **2**, 346.

<sup>2</sup> *British Medical Journal*, 1975, **3**, 497.

<sup>3</sup> *British Medical Journal*, 1975, **4**, 54.

<sup>4</sup> *British Medical Journal*, 1975, **4**, 235.

<sup>5</sup> *British Medical Journal*, 1975, **4**, 771.