In addition to maceration and the bacterial flora, in most cases the precipitating factor in setting up inflammation is, as you say, "the scratching finger (and finger-nail) attempting to relieve the almost invariable itching." To the finger (and finger-nail) should be added the many other objects patients admit they use to relieve the itch or other sensations they have either as a result of the maceration or as a result of referred sensations from other sources such as dental disorders. Questioning usually reveals that the scratching etc. precedes the infection and thus it could be said that the external otitis is a self-inflicted disease in such cases. Scuba divers are taught and professional divers know that they must not scratch, pick at, poke, or rub in or around the ear or they will develop external otitis. In fact, in Wright and Alexander's study the unusual feature that these professional divers should all develop external otitis was probably due to the repeated daily assault on the increasingly macerated skin by the cotton-wool-tipped ear swabs poked in and rubbed around.—I am, etc.,

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Lactose Intolerance in San Populations

SIR,—We have been interested to read the comments of Dr. J. M. Pettifor and Professor J. D. L. Hansen (20 July, p. 173) on our paper (6 April, p. 23). Their initial semantic point is well made. We can only plead that our usage of the term lactose intolerance rather than malabsorption conforms with that of the authorities we cited and of one which has recently come to our notice¹; we consequently presume the term to be the accepted one for a deficiency, or absence, of intestinal lactase. The test we employed appears, moreover, to be the standard one for the detection of lactose intolerance. It is true that any analogy with the glucose tolerance test, in which intolerance produces an abnormal rise in blood sugar, is misleading; but we must disclaim responsibility for this inconsistency in terminology.

We did emphasize the point that removal of lactose by fermentation, a safe and simple procedure if lactobacillus is used and one well in accord with the traditional practices at least of Bantu-speaking Negroes, would make the administration of milk safer. This would apply whether intolerance or malabsorption were responsible for the well-established dangers of giving lactose to children in Africa.² Adults are, admittedly, unlikely to drink 1½ litres of reconstituted cow's milk a day, but unsophisticated people faced with a flour-like food powder might well treat it as flour. It is not unknown for dried milk powder to be mixed into porridge in quite large quantities as part of feeding schemes.

As our recent letter (29 June, p. 728) will have indicated, we have come to suspect that intestinal lactase may well be induced in the Nama, a pastoral Khoisan people, and that

this induction phenomenon tends in part to obscure the genetic polymorphism. It would consequently appear that the latter is best investigated in a population of young children. This raises a number of ethical points. Our sample of Nama children was drawn with the consent of parents, school authorities, and local health authorities. The children had the test explained to them and no pressure was put on them to volunteer. The inducement held out to them (a few sweets) was too small to be overwhelmingly attractive and it was made clear to them that it represented compensation for inconvenience and not a bribe. Not all underdeveloped peoples are as sophisticated as the Nama, however, and the question may in other places, where milk is part of the diet, lead to some hesitation. We have no data on the incidence of infantile diarrhoea among the Nama and are unable to estimate what proportion, if any, of early deaths may result from feeding with cow's milk.

The question of the nutritional status of the !Kung is not as contentious as Dr. Pettifor and Professor Hansen may make it appear. They quote the results of a single study,³ which was at variance in its conclusions from those drawn by other workers,^{5,6} including one whose sojourn among the !Kung was of long duration and who replied to the study when it was first published.⁷ None of the !Kung seen by us at Tsumkwe in July/August 1973 or again in June 1974

showed signs of clinical undernutrition, and full haematological examinations carried out on them certainly failed to disclose any nutritional anaemia. It is possible that seasonal alterations in nutritional status, so frequently encountered elsewhere in Africa,^{8,11} may affect the !Kung as well, though Lee¹² could see no reason why they should, considering the availability of food resources and the use made of them.—We are, etc.,

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TREFOR JENKINSSouth African Institute for Medical Research,
Johannesburg

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N.H.S. Consultants: Progress Report

SIR,—I shall be grateful if you will allow me to present through your correspondence columns a short report on a number of important items in the field of senior hospital medical and dental staff. A great deal has been happening during the summer recess, but because in some cases discussion of these matters is not yet concluded it is impossible to make a full and formal report through the usual channels.

In its fourth report the Halsbury Review Body expressed concern about doctors and dentists having fallen behind in remuneration. Now that phase 3 of counterinflation legislation is ended we believe that the Review Body is free to exercise its independence and we have therefore submitted to it through the Joint Evidence Committee a written request for an interim award of 18%. This was backed up by oral evidence given to the Review Body at a meeting on 9 September. The Government, through the Department of Health and Social Security, has also submitted written evidence to the Review Body, saying that it sees no justification for any increase in salaries at present.

Throughout August and September panels of the consultants' working party chaired by Dr. David Owen have continued to meet. Undoubtedly discussion of contracts in this forum has broken the log-jam which for two years existed in "the usual channels." Progress is being made. In this context both we—that is, the Central Committee for Hospital Medical Services—and the working party itself have issued questionnaires to consultants for completion. I am most grateful to the thousands of senior staff and some senior registrars who have completed replies to our own inquiry. No doubt many are

replying also to the different questions put to them by the Owen working party about the shape of their average working week.

Among the staff members of the Owen working party are the president and immediate past president of the Hospital Consultants and Specialists Association. The whole "staff side" is working as one team. I have no doubt that this friendly and close collaboration between representatives of the C.C.H.M.S. and Mr. Beatson and Dr. Winter will be to the benefit of all consultants—both present and future. Also I am hopeful that by working together it may lead us towards a basis for agreement between our two associations.

The Owen working party has every aspect of terms of service in its general remit save for levels of remuneration. In addition to the contract of consultants now being studied the working party will be moving on to consider those of other senior grades, and we have also requested a special study of the problems of definition so long posed by the paragraphs in the terms of service dealing with categories I and II.

We expect soon a Departmental answer to the request made by the Joint Consultants Committee for reconsideration of all senior hospital medical officers without the special allowance. Further, our negotiators have recently met representatives of our Medical Assistants Subcommittee to discuss their own proposals for reform of contract.

Following the pay-bed crisis meeting of early July with the Secretary of State we have been keeping a close eye on the position and on threats and encroachments resulting from irregular trade union action locally. Through the Health Departments we

have sought to apply pressure to union headquarters to bring their branches into conformity with the agreement which was reached in their names on 5 July. I have also kept in touch personally with hospitals where problems have been particularly acute.

Lastly, I fear there is yet no progress to report on the matter of family planning services in hospitals. We are still awaiting proposals from the Health Departments for discussion. May I take this opportunity of reminding all consultants of our policy, which was set out in a statement printed in the *B.M.J.* (*Supplement*, 2 March, p. 16) and also of the guidance issued by the Government to N.H.S. authorities at that time—namely, that in general family planning services in hospitals should be maintained but not expanded pending agreement on outstanding issues between us. It continues to be our view that family planning services for social reasons are outside the terms of the present contracts. We would therefore strongly advise that no new local arrangements be entered upon until agreement has been achieved centrally.—I am, etc.,

C. E. ASTLEY

Chairman,

Central Committee for Hospital Medical Services

B.M.A. House,
London W.C.1

N.H.S. Family Planning

SIR,—As practising doctors, we would like to add the following personal comments to the stimulating correspondence in your columns on this subject.

Supply of free contraceptives from 1 April 1974 has resulted in an increase in the number of individuals attending the Family Planning Association clinics. Patients who would have otherwise gone to their general practitioners are now attending the clinics in ever-increasing numbers. Some of them come because of the preliminary and routine check-ups at the clinics; others because the age barriers have been removed. It is important to maintain the motivational and educational services rendered by the clinics—not to mention the management of problems such as psychosexual complaints, overweight, and hypochondriasis—to the same degree. The primary aim of the F.P.A. is to help people plan and limit their families in the context of personal, community, and world population problems; not just “dishing out” contraceptives. Thus there is a need to look into the currently available consultation time per patient in some of the clinics where there has been disproportionate increase in the attendance.

Many F.P.A. clinics are staffed by single-handed doctors and most of these doctors work on part-time basis. Research into the side effects of contraceptives is increasing; so also, the variety of pills available on the clinic tables. Added to this, the armchair statisticians and epidemiologists are adding masses of conflicting information to this overburdened field of medical research. Thus it becomes impossible for the part-time, lonely F.P.A. doctor to improve his or her knowledge of contraceptives in order to practice “good medicine.” Dr. M. J. V. Bull (1 June, p. 506) expressed his belief that a G.P. untrained in contraceptive practice can be expected to provide only a second-rate

service and be rewarded accordingly. Failure to provide compulsory refresher courses for the F.P.A. doctors may result in the delivery of a second-class service for first-class remuneration.—We are, etc.,

T. A. REDDY

CHRISTIAN A. M. ROAN

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Health Service Delays: New Birmingham Eye Hospital

SIR,—The failure of the Health Service is well exemplified in the delay in building a new eye hospital in Birmingham. In 1964 an inadequate pharmacy in the existing hospital led to tragic eye infections, though this inadequacy had already been firmly pointed out by medical staff in 1961. This resulted in wide publicity and press statements such as appeared in the *Sunday Times* on 21 November 1964—“A new eye hospital is urgently needed in Birmingham. . . . A three-point plan to be put to the Ministry of Health as a matter of urgency provides for extension of the hospital by the acquisition of additional premises. . . . New departments of ophthalmology to be opened as quickly as possible in other Birmingham hospitals to relieve pressure. . . . Acceleration of plans for an entirely new eye hospital.” At this time an official statement was made to the press by the Birmingham Regional Hospital Board: “It has been agreed by the authorities concerned that a new Birmingham and Midland Eye Hospital will be a part of the teaching hospital complex at Edgbaston, Birmingham, and the necessary finance will be made available as soon as the plans are completed.”

The need for a new hospital was recognized before 1939 and money was available at that time, but this money was lost to the Health Service in 1948. Nearly 40 years later we are still waiting for a new hospital which has been firmly promised at dates from 1968 onwards.

There is now little chance of a new eye hospital in Birmingham before the 1980s. This means that in the City of Birmingham adequate ophthalmic services cannot be made available for the next 10 years. Though the existing hospital will continue as always to provide the best possible service within its limited facilities, a comprehensive coverage is no longer possible. In 20 years the consultant staff have done all in their power to improve conditions, but have failed to obtain a new hospital when it was essential. This failure has already been due to a willingness to work long hours in ridiculous conditions and so allow an inefficient health service to appear to be adequate.—We are, etc.,

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M. J. ROPER-HALL

K. RUBINSTEIN

S. J. CREWS

VERNON H. SMITH

P. EUSTACE

D. R. BARRY

Birmingham and Midland Eye Hospital,
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Are our Priorities Correct?

SIR,—One London teaching hospital has been almost completed at a cost of £25m.

Many others have been lavishly extended and some rebuilt. Regional hospitals have been deprived of reasonable finance. This town has had a new hospital scheduled for 24 years, but building has yet to begin. Medical, surgical, and gynaecological cases are treated in six hospitals. Many of the wards are overcrowded and cross-infection is not uncommon.

A few months ago London teaching hospitals were attempting to recruit hernias and varicose veins to widen the scope of their teaching material. Meanwhile in the past few weeks two local residents well known to me have been admitted to superspecialist departments in the metropolis.

The first, a man of 72 who has had severe attacks of disabling bronchitis for the three years I have known him, was admitted to a cardiothoracic department for valve replacement. During intensive routine investigation he died of what was stated to be “metabolic failure.” The second, a man of 69, was admitted to a neurosurgical department for prolapsed disc. This man had had one cooked meal a week for the past five years since the death of his wife. Otherwise he had existed on cornflakes and occasional pies from the “local” where he had his daily pint. These facts were unknown in the hospital. The operation was successful but “Bill” died on the fourth post-operative day from “bronchopneumonia.”

Meanwhile, in the north of England hundreds of children with congenital heart disease wait for surgery which could be successful in many cases. The nation waits the full implementation of family planning services while the profession waits for and insists on more money. Surely we should meet this national need while bargaining for “relativities” which many other sections of the Health Service and the community submit to.—I am, etc.,

HORACE JOULES

Colchester

Maternity Services in the Community Hospital

SIR,—I would like to draw attention to the memorandum issued by the Department of Health and Social Security on the development of community hospitals in the Health Service.¹

The most significant exclusion from the work of the general practitioner hospital will be maternity services. It is true that on purely technical grounds these services should be superior in a district general hospital, but that does not gainsay any function for the smaller units. No reason prevents the antenatal division of mothers into those whose delivery might be complicated, and who therefore must attend a district general hospital, and those whose delivery is likely to be straightforward. The latter may be, and indeed will, be very reluctant to leave the community and will elect for home confinement, especially as the district general hospital may be 30 miles (48 km) away.

Confinement in the local G.P. hospital is a highly satisfactory alternative. The maternity services in this area have functioned along these lines for the past 25 years to the satisfaction of patients and doctors alike and I would regard any change from this as dangerous and retrograde.—I am, etc.,

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¹ Department of Health and Social Security. *Community Hospitals: Their Role and Development in the National Health Service*. D.H.S.S., 1974.