Correspondence

Letters to the Editor should not exceed 500 words.

Revision of the Association's Constitution

Sir,—Dr. E. R. C. Walker (5 December, p. 1458) and Mr. N. G. C. Hendry (23 January, p. 247) have wisely reminded us that before we design a new constitution for the B.M.A. we should do some deep thinking on what the Association's purpose should be. Well, here are some thoughts. Much of our trouble derives from the fact that since 1948, if not since 1911, we have allowed ourselves to become a nearly indispensible branch of the Government's administrative machine, and have appeared positively to welcome it, and this has hung upon us like the abattores. Professor Eckstein (1960), in his book Pressure Group Politics, wrote that if in 1948 the B.M.A. had not existed the Government would have had to invent it. We should aim to disengage ourselves from this invidious position.

Through little fault of its own the G.M.S. Committee is the source of most of the odium that has been piled on the B.M.A., and I think we should return it, the Committee, with thanks to its rightful home the Conference of L.M.C.s, whose executive it is. This would get rid of the farce of the Conference and the A.R.M. dealing with the same business, at inordinate length, within a few days of each other, the G.M.S. Committee balancing precariously between the two and in effect playing one off against the other. The Conference and the Committee can and should stand on their own feet. Together they form the logical representative organization for the general-practitioner services in the N.H.S. The B.M.A. has done itself much harm by pretending that it is the heaven-sent, all-powerful, and all-representative organ for this purpose.

In the hospital field an acceptable representative organization is also needed. The C.C. and S. Committee should enlarge its "autonomy" into independence, finance itself by a voluntary levy as the C.C. and S. Committee (Scotland) has done for many years, and remain a constituent part of a continuing Joint Consultants' Committee until the Royal Colleges see the light and join the democratically organized representative structure which the C.C. and S. Committee is now.

These two major sectional committees should cease to be standing committees of the Council. Shorn of the medico-political incubus the B.M.A. could devote itself to the true pursuit of its objects. "To maintain the honour and integrity of the medical profession" it should retain its peripheral and central ethical machinery, and, to negotiate fees for non-Governmental work, matters concerned with private practice, benefit schemes, and homes for aged doctors, retain its Private Practice Committee. The affairs of public health medical officers should probably best be returned wholly to the Society of Medical Officers of Health.

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"To promote the medical and allied sciences" the B.M.A. should expand its distribution to the profession and the world of the results of research and medical thought by fostering and expanding its medical publishing business. The activities of the Committee on Medical Science, Education, and Research must also be fostered and expanded especially in the field of medical education—annual scientific meetings, clinical meetings, central lectures, local lectures, clinical meetings, scholarships, etc., co-operating massively with all other organizations in this field—postgraduate, postgraduate federations, and associations.

If purposes like those above were pursued wholeheartedly not only would the B.M.A. stand some chance of refurbishing its tarnished image but it would spare itself the cost of a great deal of unwarranting central committee and secretarial work and might be able to live within its income. It might also find that root and branch reorganization of its constitution was unnecessary after all.—I am, etc.,

Edinburgh 9.

J. G. M. Hamilton.

Training of Surgeons

Sir,—You were kind enough to publish on 23 January (p. 245) a note from the President on the new Regulations for the Final Fellowship Examination of this College, and to add some comments of your own in a leading article (p. 208).

The second paragraph of your own editorial comment might be read to imply that the College is only now beginning to adopt the practice of visiting hospitals and approving central medical posts. In fact there is nothing new in the College's insistence on pre-Fellowship training being obtained in approved hospital appointments. The College has for many years inspected training posts in hospitals which apply for recognition under the Fellowship regulations. These inspections are carried out in order to ensure that the trainee receives proper supervision and teaching, that he has adequate time for study, and that the hospital provides suitable library facilities. They are indeed designed to achieve the very objects which you yourself have stated so clearly in your editorial comment. What the new regulations do is to require an additional year in training posts in hospitals approved in this way.

The College fully recognizes the desirability of ensuring that as soon as possible all training posts in hospitals throughout the country should provide these essential training facilities for their junior staff, and that young men in training will no longer be "used simply as pairs of hands." The pilot scheme for surgical tutors and the appointment of regional advisers are methods already adopted with these ends in view, and the College will continue to use its influence by every means in its power to achieve them.

The College can thus fairly claim that, by inspection of hospitals applying for recognition, it has already done much to improve the supervision and training facilities given to young surgeons in hospitals throughout the country.—I am, etc.,

C. Naughton Morgan, C.M.G.
Vice-President.
Royal College of Surgeons of England.
London W.C.2.

Tuberculous Immigrants

Sir,—Your leading articles (19 December, p. 1547, and 23 January, p. 208) have deplored the Ministry's failure to arrange for chest x-ray examination of all immigrants on arrival in the United Kingdom and announced the setting up of a B.M.A. working party to investigate the problem of importation of communicable diseases.

The radiological control of tuberculosis by chest x-ray of all immigrants presents many problems.

(1) There are many ports of entry to the United Kingdom. If chest x-ray examination becomes obligatory at London Airport only this fact would soon be known to intending immigrants, who would make arrangements to use another port of entry.

(2) Air-line operators and airport administrative staff are primarily concerned to move immigrants off the aircraft and through the airport as quickly as possible. Any delay caused by medical examinations (including chest x-ray) is resented and the procedure opposed.

(3) It may be difficult to provide enough radiographers to give a 24-hour service because of the present staff shortage.

(4) Many Asian immigrants do not speak English and either radiographers speaking Urdu or Bengali would have to be recruited or interpreters provided.

With a conventional 100 mm. mirror camera unit and standard film processing a batch of 50 films can be produced ready to read in 45-60 minutes. Using an automatic film-processing machine films are available 15 minutes after the exposure. By modifying a 5 in. by 4 in. (13 by 10 cm.) lens camera unit to take polaroid film a positive print is available in less than one minute. The latter film is not the high quality obtained by conventional means, but it does give a film adequate to see significant tuberculosis disease for inspection by the port medical officer before the immigrant has had time to get his jacket and overcoat on.

The language problem can be reduced by use of pre-recorded instructions on tape explaining in the appropriate language the x-ray procedure.

Co-operation of air line staff and airport administrators is essential; the port medical officer must have full authority to ensure that
no immigrant leaves the port health area un-
checked.

May I suggest that in addition to the
members already recruited for the B.M.A.
working party the services of an experienced
mass radiography unit director are secured.
The planning and organization of a large
number of people through a chest x-ray
apparatus the same time as for a mass
radiography unit medical director.—I am,

F. J. H. WALTERS.
Mass Radiography Service,
S. W. Metropolitan Regional Hospital Board,
Worcester Park,
Surrey.

SIR,—As regards the medical examination of
immigrants, which is under discussion at
present, I would like to advocate that Man-
toux testing should be carried out as well as
mass radiography. We have had quite a
number of them as patients here with bone
and joint tuberculosis without there being a
demonstrable chest lesion. This might apply
more frequently if we compare the situation
here from the person from Aden than to
the person from Pakistan, but this is only
an impression. If the Mantoux test proved
to be negative, B.C.G. could then be offered,
and I think in many cases it would be readily
accepted, etc.

King Edward VII
Orthopaedic Hospital,
Sheffield.

E. G. HERZOG.

Treatment of Ulcerative Colitis

SIR,—I was most interested to read of the
experiences of a double-barrelled ileostomy in
ulcerative colitis and Crohn's disease of the
colon by Dr. S. C. Truelove and others (16
January, p. 145).

Having had a relatively extensive experi-
ence of these diseases, particularly of ulcer-
ative colitis, I am rather dismayed at the
advocacy of what appears to me to be a retro-
grade step which, if generally adopted, will
perpetuate the miseries of many patients.
I feel the time has come for the frank
expression of experiences. After many years
two principles of the surgical management of
ulcerative colitis seem to have emerged.
Firstly, that the facal stream should be
totally diverted from the inflamed and ulcer-
ated colon by an ileostomy, and, secondly,
after much tribulation and sacrifice, that a
complete restoration to health cannot be
achieved without ablation of all the diseased
bowel. Recrudescence of the disease, some-
times fulminating, has occurred where any
of the colon has been retained and complica-
tions remote from the bowel may still occur
(uloidcolitis, arthritis, pyoderma, etc.).

A special study has been made in this
centre of changes in the colon which represen-
ta stage of the disease from which no
recovery has occurred in spite of the use of
all known medical measures. These changes,
which can be recognized radiologically, have
been followed in patients for months and
years, and a relentless progression of the
disease has been noted.1 Many centres with
a special experience of ulcerative colitis report
a risk of carcinoma, when the disease has
been present for ten or more years, that would
terrify those concerned with the suppression
of smoking had it been related to lung cancer.
To me this risk justifies a prophylactic col-
tomy when the disease has been radiologically
apparent for ten years or as soon as the
patient himself comes to appreciate his pote-
tion when irreversible signs have appeared.
To continue to treat a disease which has
come irreversible is merely to squander blood
and expose patients to the continued use of
adrenal corticosteroids, which themselves
are associated in many cases with sinister and
sometimes dangerous effects.

Most surgeons with a special interest in
ulcerative colitis have come to appreciate that
their patients are of a dependent per-
sontality, have become demoralized by the
repeated failure of medical measures, and are
in urgent need of a treatment in which they
may have full confidence. The psychological
preparation, support, and follow-up of
patients accepting the surgical cure of their
disease far outweighs the technical argu-
ments of the excision. From close observa-
tion of a personal series of almost 100 total
colectomies without mortality, I have come
to feel that in most instances attempts to pre-
serve the colon had been unjustified. The
same sentiment comes to the patient. Table I
makes unhappy reading. What cannot be
expressed in such a table is an account of
the individual privations, unemployment, the
ugliness associated with steroid administra-
tion, the shambles of lives and the miseries
of a diet which is sometimes so restricted that
the quality of life assumes the drabness of a
mere existence. These features have certainly
been the lot of many of my cases before
surgery. My experience has been that the
patients' recollections of past and failed sur-
gical adventures enormously magnify his
difficulties in his adaptation to a properly
constructed permanent ileostomy. From the
purely technical viewpoint the presence of
scarring in the right iliac fossa from a pre-
vious ileostomy which has been closed at
some stage prejudices the adhesive potential
of the many excellent appliances on the
market at the present time.

I have been constantly impressed by the
gratuitous remark of the majority of mem-
bers of a division of the Ileostomy Associa-
tion that they wish they had been offered the
surgical cure of their condition at a much
earlier stage, when they could have avoided
the mannered mannerisms, and the miseries
of a diet when they could least afford it.—I am,

Department of Surgery,
F. C. WALKER.
The Medical School,
University of Newcastle upon Tyne.

REFERENCE

Steroid Addiction in Ulcerative Colitis

SIR,—I was stimulated to write and com-
ment on the letter on steroid addiction in
ulcerative colitis (12 December, p. 1528) in
that I am one of those who, according to
Dr. M. Kelly, have "shut their eyes to the
pretoridestraight rate in colitis of less than
2% per year." Though his pretoridestraight
rate was incorrect, his letter significantly lessens
his arguments opposing steroid therapy to my satisfaction. I
would like to call to your attention that one of
the steroid protagonists has compared the
death rate in the past before and after
steroids,3 as he required, with a mean
follow-up in the steroid era (9 years) reason-
ably approaching that in the presteroid era
(12 years). This study revealed a fall in mor-
tality of from 21 to 8 per 100,000. Steroid-era
devices often occurred early in the decade
when experience was just being accumulated
with hormonal therapy. The mortality rate
of ulcerative colitis in the steroid era would
be still smaller if it represented in addition
the cases not operated with steroids.

I am sensitive to Dr. Kelly's expressive
reaction to steroid therapy in ulcerative colitis
when I recall the occasional case when a
fatal complication had been steroid-
accentuated. More optimistically, however,
the course of ulcerative colitis has been
altered by steroid therapy, so that the severe
attack is terminated more swiftly, the patient
is more likely to be completely well between
attacks and spend less time in the hospital,
an opportunity is offered for more elective
and less urgent surgical procedures, and the fatality
rate is markedly lessens. All of these
advantages are proportional to the skill with
which these drugs are utilized with regard
to the natural course of the disease.

In summary, if one must have ulcerative
colitis, he should prefer to have it in the
steroid rather than in the presteroid era.—I am,

New York 28, U.S.A. BURTON I. KORLITZ.

REFERENCES
1 Blythe, B. M., Korelitz, B. L., and Zettel, L., Gastroenterology, 1957, 32, 983.
2 Korelitz, B. L., and Lindner, A. E., ibid., 1964, 48, 671.

Double-barrelled Ileostomies

SIR,—I was most interested in the excellent
article on the above subject by Dr. S. C.
Truelove and others (16 January, p. 150),
but was rather concerned that such author-
itative people should use terminology so
loosely. I had to read their opening para-
graph several times before I realized that two
quite separate ileostomies were described by
them as "double-barrelled."

I do not wish to quibble, but as the opera-
tion of double-barrelled ileostomy has already
been used in this condition one feels it is
highly misleading to use the term for a quite
different operation.—I am, etc.

Ashford, Middlesex.

ROBIN BURRITT.

Post-mortem Caesarean Section

SIR,—I was particularly interested in your
leading article on post-mortem caesarean
section (23 January, p. 204), as apparently
I am one of the few doctors who have per-
fomed the operation. I was pleased to learn
that I had done the right thing in the right
way.

About 30 years ago when I was in practice
in Derby I was called urgently to a woman
who I had advised to get as much bed rest as
possible because I found she had hypertension
when nearing confinement. I found her uncon-
scious; not having an eclamptic seizure, but in
a state of cerebrovascular rigidity, and decided she
did not suffer an intraventricular cerebral
haemorrhage. She was obviously in a very bad
way and while I was examining her and collecting my
thoughts and telling the husband I was afraid she
was going to die, she died.

We had been advised as students to carry a
scalpel around when we were in practice as in case
we were called on to perform an emergency