The Democratic Processes

Autonomy was ostensibly the prime issue at the Hospital Junior Staffs Group Council's meeting last week. But, as the report in the Supplement (p. 73) shows, the debate disclosed a more fundamental problem than just the relation between the Group Council and the rest of the B.M.A. How can juniors take full advantage of the democratic processes of the Association—centrally or regionally—when to do so takes up more time than they can afford to spare from looking after their patients and making their careers? This dilemma is not peculiar to young doctors in training—or even to doctors—but it is undoubtedly acute for them.

Representation for the younger members has recently greatly improved throughout the Association's complicated committee structure—nowhere more so than in the Central Committee for Hospital Medical Services. Nevertheless, progress in getting the juniors' views to the negotiating table has been too slow, according to the Group Council, even though the seniors might argue that this was merely the operation of the checks and balances inherent in any thorough democratic procedure. Furthermore, the seniors, particularly the regional consultants, have serious problems of their own, and the difficulties of advancing the juniors' cause without simultaneously sacrificing some of the legitimate interests of the consultants are not easily resolved.

However, the apparent delays in negotiations worried some speakers, who saw them as precipitating a crisis of confidence, not only among their colleagues in the training grades but also among medical students. The niceties of committee procedure and broad consultation are of little interest to the houseman spending his weekly 100 plus hours on call. He wants prompt political action on his behalf, and if the B.M.A. seems unable to provide it he will go elsewhere. Mr. F. J. Bramble made it clear to his Council that his aim was to obtain the right answer to the juniors' representation within the B.M.A., and he was prepared to be an uncompromising thorn in his seniors' sides to achieve this. For all that the sincerity of the arguments deployed was obvious, and Sir Paul Chambers, invited to the meeting by Mr. Bramble, cannot fail to have been impressed by their case. His report on the B.M.A.'s constitution is expected soon, but whatever the fate of its recommendations any changes in the B.M.A.'s constitution flowing from them could not mature until mid-1974. The Group Council is not prepared to wait that long. There are several major and urgent issues facing the juniors, and, though members of the Group Council differed on the means of achieving what they wanted, they all sought a speeding up of their negotiating processes as well as direct access to the Department of Health when necessary.

The Group Council realized that if it had autonomy it might lose its present substantial holding in the C.C.H.M.S., and the demands on the juniors' time because of cross-representation might well be greater even than now. So appreciating that at the moment autonomy might create as many problems as it solved, the meeting eventually decided on a composite motion. Initially the C.C.H.M.S. is to be asked to allow the juniors quicker direct access to the Department about terms and conditions of service of hospital junior staff. But if this moderate approach is blocked, then this year's A.R.M. may well hear a second round of the debate on junior representation which took place at Aberdeen in 1969. But with common sense and goodwill on all sides this issue can and should be resolved without a complete rift between seniors and juniors, for that could only be harmful to the medical profession as a whole.

Medical Superintendents: Farewell and Hail

A distaste for administration, even a certain contempt for it, has long been traditional among clinicians in Britain. The contrast with countries overseas is striking. Despite the many advantages to medical practice of having properly trained administrators who are also medical men few doctors have felt drawn to this (as it is) special branch of medicine. That there are regional differences is exemplified by the well-known preference for medical superintendents of hospitals in Scotland, but doctors abroad are often surprised at an observation the late Professor J. M. Mackintosh used to make—namely, that the United Kingdom and Abyssinia were the only two countries in which the head of the medical service was not a doctor.1

In England and Wales the place of the medical superintendents was so secure and full of promise as far back as 1886 that they founded a society to further their common interests. Now 86 years later the Medical Superintendents' Society has wound up its affairs, and many of its members as well as other doctors will share the hope of Dr. W. A. S. Falla, the chairman of its council, who writes in our correspondence columns this week (page 745): “The importance of the medical aspects of administration in the National Health Service, now and in the future, is by no means diminished by this step, but, on the contrary, will be enhanced.” But if medical superintendents as such are on the way out, they are becoming part of the larger and more varied body of medical administrators, and it is greatly to be hoped that these will continue to increase in numbers and influence, for, as Dr. Falla says, doctors must have effective management functions in the Health Service of the future.

When the Medical Superintendents' Society was established many general hospitals and all the psychiatric hospitals were managed by doctors who combined clinical and administrative functions. This system was considered to be in the best interests of the patients. Now ideas have changed, though whether our present hospital administration is any more efficient in furthering the welfare of patients than was the system of medical hospital management is questionable, for a lack of clear medical policy in hospitals nowadays frequently leads to indecision, delay, and frustration. Patients, relatives, visitors, and the nursing and medical staffs are too often uncertain about matters of general policy. This is particularly true of our psychiatric hospitals, where all aspects of the daily life of the patient are so closely related to therapeutic management that they cannot be separated satisfactorily.

Though the Medical Superintendents' Society has resisted the growing tide of adverse opinion to the principles of medical management for many years, dwindling membership and lack of interest have brought about conditions which render impossible the continuation of the society in its original

1 British Medical Journal Supplement, 1971, 4, 55.
form. But the recently formed Medical Administrators’ Group of the B.M.A. will carry on and extend the principles instituted by the early pioneers and defended so faithfully by a long succession of devoted followers. It is to be hoped that the society’s ideals will continue to influence the conduct of medical affairs and will find expression in the wider field of medical management.


**Paget’s Disease of the Skin**

It is nearly a century since Sir James Paget first described the eczematoid lesion of the skin that bears his name.1 This is found most often on the nipple and areola of the breast, but has also been described on the penis,2 vulva,3 axilla,4 and eyelid,5 and in the mucosa of the oesophagus and larynx.6

Histologically there is an infiltration of large, round Paget cells, singly or in groups, throughout the lower part of the epidermis. These have a pale, clear cytoplasm and a large vesicular nucleus, in which there may be a prominent nucleolus. Histochemical stains sometimes show much mucopolysaccharide in the cytoplasm, especially in lesions of the anus7 and vulva, but this is not the rule with mammary Paget’s disease.7 In most cases affecting the breast there is an underlying carcinoma, usually affecting the superficial ducts and contiguous with the skin lesion—though sometimes it is deep-seated and quite separate. Most cases of perianal Paget’s disease are also associated with an underlying adenocarcinoma, probably arising from neighbouring apocrine glands.2 But in Paget’s disease of the skin in other sites no underlying malignancy can usually be found.

M. E. Fenn and her colleagues have recently reported seven cases of Paget’s disease of the vulva.8 In all of them the Paget cells, which were rich in mucopolysaccharide, were found in neighbouring plexiform structures as well as in the epidermis, and in two cases the sweat ducts were also involved. In no instance was there an underlying invasive carcinoma, but three patients had a primary cancer elsewhere in the body, either at the time of treatment or previously. One patient had had four primary malignant tumours in addition to Paget’s disease over the previous 24 years.

The pathogenesis of Paget’s disease has occasioned much controversy. The original view was that it represented an intraepithelial invasion of cancer cells from an underlying carcinoma of a breast duct or an adenexal apocrine gland. Nevertheless, the distance of this tumour from the skin in some cases and its absence in others make this hypothesis frequently unacceptable. There is now a growing consensus of opinion that Paget cells arise in the actual epithelium, and that Paget’s disease itself is a type of intraepithelial cancer. In some instances a transition to Bowen’s disease (intraepidermal carcinoma) is evident,9 as in two of the patients described by Fenn and her colleagues.8 Thus while intraepithelial spread might account for a few of those cases of Paget’s disease with an underlying carcinoma, more probably these lesions represent a multifocal primary cancer arising in an extensive field of neoplasia. In all cases of Paget’s disease it is important to exclude invasive cancer, not only in the vicinity of the lesion but also elsewhere in the body.

1 Paget, J., St. Bartholomew’s Hospital Reports, 1874, 10, 87.

**Contaminated Drip Fluid**

Sterilizing bulk supplies is recognized to be an inherently difficult process. Because of the scale of operations only steam sterilization can be used; one container may be adequately sterilized while its neighbour is not; and there is still no certain indicator that the entire contents of an autoclave have been sterilized. To avoid the presence of pyrogens in the final product particular emphasis has been placed on aseptic conditions, and special sterilizing cycles and designs for infusion bottles have also been developed. As a final check the usual practice after the autoclaving process is to test a random sample of the bottles bacteriologically. Nevertheless, clearly the bottles which are used for actual infusions cannot be sampled in this way.

With all these precautions only one previous episode involving fatality from contaminated drip fluid has apparently been reported in Britain in recent years,1 and doctors have been able to set up a drip confident that the infusion solution is sterile as that in any drug amouple. Yet if contamination has escaped detection by routine checks it may unfortunately be revealed only by the occurrence of rigors, severe illness, or even death in the patients receiving the fluid. Thus any inquiry into the recently reported contamination of dextrose solution should ask several questions. Where did the contamination arise—in the distilled water used for preparing the solution, or in the cooling process used after autoclaving? Were these episodes caused by live organisms—and if so why were they so uniformly serious—or by endotoxins? If the solution was initially contaminated by bacteria why were these not killed by autoclaving? Do the tests for sterility and pyrogens suggested in the British Pharmacopoeia give adequate protection? Are they carried out at a stage in the process likely to reveal contamination? And, if not, is there a case for sampling after the bottles have been set aside for some time? All these questions must be answered satisfactorily, for, though contamination of intravenous fluid seems very rare, its effects are so disastrous that this episode must not be repeated.

1 British Medical Journal, 1966, 2, 597.

**Birth Control Campaign**

Public opinion seems to be moving in favour of wider provision of contraceptive advice and appliances, and there is increasing pressure to include these services within the