Unease among Hospital Doctors

Junior doctors working in the N.H.S. have had their share of disputes with governments over the years. Though governments have recognized their problems they have always seemed to be in no hurry to apply any remedies—presumably because the root obstacle has usually been shortage of money. However, study time and time off¹ as well as excessive work load² were instances where the Government eventually acted after prolonged professional nagging. But attempts to persuade the Department of Health to improve standards of accommodation have met with rather less success, for though Sir Keith Joseph has promised to set aside £1 m. in 1973 “to be used exclusively for the up-grading of residential accommodation”³ not all of this will go towards doctors’ accommodation and the deficiencies will need more than £1 m. to put them right.

On one other matter that has been particularly worrying junior doctors there has been no progress. Discussions between the B.M.A. and the Department of Health on adequate financial protection for hospital doctors facing special hazards in their N.H.S. work have now dragged on for about two years.⁴

In July 1972 as an impasse seemed to have been reached the Hospital Junior Staffs Group Council asked the profession’s representatives to approach the Department of Employment to arrange for arbitration under the Industrial Courts Act 1919. By Christmas despite prodding from the profession the Department of Health had not replied to this request. Thus because the consent of both parties to a dispute is required before arbitration can start, nothing has happened so far, though Sir Keith Joseph has twice discussed the problem with the B.M.A. and promised a reply in February.

Dr. C. E. Astley, Chairman of the Central Committee for Hospital Medical Services, has now drawn attention to the dispute in the lay press,⁵ mentioning particularly the risks facing doctors taking part in flying squad duties or working in dialysis units. Doctors will be the first to acknowledge that other workers in the health services such as nurses, ambulance men, and laboratory technicians face similar hazards, and the N.H.S. superannuation scheme—at present under review—makes some provisions for staff accidents in the course of duty. Accidents to N.H.S. staff on flying squad duty are not frequent and the screening of patients and staff has reduced the risk of working in dialysis units.⁶ Nevertheless, the death or serious injury of the breadwinner is a shattering financial as well as emotional blow to a family. Furthermore, the junior doctors see themselves in a unique position because the long-term financial loss to their families in the event of a tragedy is potentially greater than that for other N.H.S. staff. They therefore argue that existing N.H.S. provisions are inadequate, with the Secretary of State’s discretionary powers playing a key part in any decision on benefit. According to a recent letter in the B.M.J.⁷ this lack of adequate “insurance cover” is already affecting the planning of “exercises for major disasters,” and the situation has come to a head in two hospital regions where staff representations have prompted the boards to consider starting their own schemes for compensation. If regional boards acknowledge that there is a case to answer then the Department of Health should at least accept the call for arbitration.

The juniors’ representatives are doubly irritated by the protracted talks about special risks, because apart from their conviction of the justice of the case they view the delay as symptomatic of the Government’s seemingly lackadaisical approach to all their problems. This attitude was apparent well before the present general incomes freeze seized up any negotiations with financial implications, for apart from the discussions on special risks negotiations to revise the extra-duty payments scheme—started at the end of 1971—have made little progress. It was cumulative frustration over their relations with the Government that finally prompted the juniors’ representatives to withdraw in the middle of the last negotiating session with the Department of Health. Such a decision cannot have been lightly taken and the H. J. S. Group Council is to review the whole position when it meets next week.

Though the senior negotiators did not withdraw, discontent is not confined to the juniors. Mr. A. H. Grabham, Chairman of the C.C.H.M.S. Negotiating Committee, has condemned the Government’s attitude, and comments at the January meeting of the main committee demonstrate the unease that exists among hospital doctors. The Government should respond to these symptoms of discontent and show its willingness to talk seriously. Otherwise the unease may grow into something worse. A year in which the N.H.S. is being

⁴ Gust, I. D., Australian Journal of Experimental Biology and Medical Sciences, 1971, 49, 625.
reorganized is hardly the best time for the Government and a major part of the profession to have their backs to each other.

2 British Medical Journal Supplement, 1968, 1, 73.
3 British Medical Journal, 1972, 4, 621.
5 The Daily Telegraph, 5 January, p. 16.

Tests on CS for Carcinogenicity

The possibility that man-made chemicals may increase the risk of cancer development among those exposed to them has been regarded more and more seriously during the past two decades. Today various regulatory bodies effectively prevent the introduction of new food additives, pesticides, or drugs until and unless it is reasonably certain that they will not cause cancer as judged by tests on laboratory animals. Moreover, there is an increasing awareness of the need to ensure that people are not exposed to carcinogenic chemicals at work. Against this background there has been some concern that the anti-riot gas CS may be a carcinogen.

In 1971 a Home Office report1 on the medical and toxicological aspects of CS gas (ortho-chlorobenzylidene malononitrile) concluded that “there are at present no experimental indications that long-term effects, like cancer, might develop after recovery from the early effects of inhaled CS smoke, but a more definite assessment of the risks, if any, of such occurring must await the completion of survival experiments on animals still in progress.” The view expressed in this report to the effect that CS is probably not carcinogenic was based on circumstantial evidence. Chemically CS is not similar to any known carcinogen and it is not broken down to form one. People exposed to it do not develop chromosomal abnormalities. The damage that occurs in the livers of animals exposed to CS is not of a kind seen in animals exposed to known carcinogens. What was missing at the time of the Home Office’s report was information about the long-term effects of CS on the lungs of animals exposed to it by inhalation. That information is still missing, and reviews of other information on toxicity, such as that by G. R. N. Jones,2 however comprehensive, are no substitute.

Meanwhile speculation about the possible carcinogenicity of CS gas continues. D. H. Barry and his colleagues at the Huntingdon Research Centre recently reported3 that CS suppresses the non-specific esterase activity in the sebaceous glands of mouse skin. The effect, they say, is exhibited by well-known carcinogens and by tobacco condensates but not by any of the non-carcinogens and irritants that have so far been tested.4 5 However, the published evidence for this claim needs confirmation and further study. Weakly positive results were given by chrysene, pyrene, fluoranthene, anthracene, and 1,2-benzanthracene. All of these are polycyclic aromatic hydrocarbons. Chrysene and 1,2-benzanthracene are thought to be weak carcinogens and the other three to be non-carcinogenic. Previously published evidence points to a more general correlation between carcinogenicity and the ability of a variety of chemical compounds to destroy sebaceous glands, but colchicine, a non-carcinogen, was found to show considerable activity of this kind.6

If CS gas is proved to be a carcinogen it would not be the first “war” gas found to carry such a hazard. Men exposed to mustard gas (either in trenches or in its manufacture) during the first world war experienced a higher risk of developing lung cancer than men not exposed to it.7 A passage in the Home Office report is pertinent to the possibility of hazards from CS: “If the competent authorities feel it justifiable to release a chemical agent for use in civil circumstances, then medical and scientific research relevant to this decision should straight away be published in the appropriate scientific journals so that informed medical and scientific opinion may assess the situation for itself.” When, we may ask, will the results of thorough, long-term carcinogenicity studies be published?

7 Beebe, G. W., Journal of the National Cancer Institute, 1960, 25, 1231.
8 Wade, S., Miyamishi, M., Nishimoto, Y., Kambe, S., and Miller, R. W., Lancet, 1968, 1, 1161.

Slow Virus Infections

No longer are only acute diseases attributed to viruses. Evidence is accumulating that viruses may cause a variety of subacute or chronic degenerative, and even neoplastic, conditions. They may be true viruses with核酸 acid cores, or slow viruses, which appear to be without nucleic acid and whose mode of self-replication remains uncertain. Persistent, latent, and slow virus infections are reviewed and discussed in a most interesting recent symposium published by the Royal College of Pathologists.1

The best-studied persistent infection is lymphocytic choriomeningitis in neonatally infected mice, in which glomerulonephritis results from immune complex disease.2 In terms of pathogenetic mechanisms interesting parallels can be drawn between this infection and serum hepatitis in man.3 In both cases the disease appears to be attributable to allergic responses to the infection. Cytomegalovirus infections,4 until recently little known, are now recognized to be widely distributed and may be an important and preventable cause of mental deficiency. In cats a persistent virus infection is implicated in the aetiology of leukaemia,5 and such infections may be relevant to neoplastic disease in man.

Latent infections which recrudesce to cause disease are epitomized by the varicella-zoster relationship.6 Latency is a notable characteristic of herpesviruses. They can replicate in cells without killing them and may possibly be oncogenic. The Epstein-Barr virus is associated with Burkitt’s tumour and with nasopharyngeal carcinomas,7 and several animal herpesviruses appear to be oncogenic.8 Subacute sclerosing panencephalitis9 is an example of slow recrudescence of a latent infection (measles), probably in the presence of a specific immunological defect, leading to progressive destructive changes in the central nervous system.

Slow viruses have now been detected in association with two subacute degenerative diseases in man of the central nervous system10 (kuru and presenile dementia or Creutz-