But these changes, beneficial in themselves, leave unanswered the main question: How relevant is the M.R.C.P. examination to the selection of future physicians? The Royal Commission on Medical Education had no use for "a single major 'pass or fail' examination" for assessing performance in its three-year period of general professional training. It preferred reports from supervisors and chiefs of units, and thought that satisfactory completion of this training should be regarded as evidence of eligibility for college memberships. The Royal College of Physicians of London, however, argues that there is still a place for a standardized test of sound basic knowledge of medicine and fitness to pursue further specialized training, and that candidates would themselves want an unbiased assessment such as a common M.R.C.P. could provide. This is an argument that needs settling before the new diploma becomes entrenched.

**Spotting Typhoid**

British holiday-makers returning from abroad this week have been met by newspaper placards of typhoid outbreaks. Family doctors will need to be alert to the possibility of typhoid among their patients, though its early recognition is by no means easy.

Typhoid is a good mimic, and any continuing fever should arouse suspicion. Indeed, "typhoid or paratyphoid fever should be considered as a possible diagnosis in any person who has had fever, rigors, or pyrexia for three days or more; if the patient has recently been abroad it should be considered from the first day of illness."

If the diagnosis is suspected, the medical officer of health should be consulted by telephone; blood should be taken for culture and Widal testing at once. Specimens of faeces and urine should also be taken for culture; contrary to general opinion, based on earlier bacteriological techniques, these are usually positive in the first week of illness.

During the first week there are no specific diagnostic features. Usually there is a rising fever, with morning remissions, a pulse rate of 80-90, and progressive lassitude and malaise. The tongue is coated, there may be sordes, and the skin is dry and musty. The abdomen is slightly tender, with a doughy feel, and the patient may be constipated at this stage. Often there is a mild bronchitis.

In the second week the clinical picture becomes clearer, particularly if the classical scanty rose spots are found after the seventh day. The fever reaches its height at this stage; toxæmia is marked, and the soft, tender spleen may become palpable. The abdomen becomes distended, and the stools may become loose, but the patient may be constipated. By the third week the disease is well advanced.

By the second week of the illness there should be no difficulty in confirming the diagnosis bacteriologically by culture of faeces and urine; in a febrile patient the organism may still be present in the bloodstream. The Widal test is positive, but its interpretation may be difficult in a patient who has had T.A.B. vaccine, so it is important to do a Widal test as early as possible in the illness so that any later rise in titre may be detected.

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**Success and Failure**

Until lately doctors' failures to cure their patients caused more concern than their therapeutic successes. But the efficacy of some of the new methods of resuscitation, repair, and replacement of tissues or whole organs is presenting the medical profession with dilemmas much sharper than were known to earlier generations. Success is beginning to provoke as much thought as failure. A doctor's natural reaction to do all he can to preserve his patient's life is stilled only by the firm belief that it will be a fruitless interference likely to bring his patient nothing but further suffering. A painful example of the failure to let nature take its course was recorded last year by W. St. C. Symmers, and W. Ritchie Russell added that it was but an extreme example of what may be observed in the wards of every hospital in the country.

But what is nature's course? And when should the doctor refrain from interfering with it? Circumstances must differ in individual cases, and in none can the problem be more acute than when the patient is a newborn baby who at best is faced with a life of gross disability, perhaps mental as well as physical. J. S. Lawson, of Melbourne, has discussed the ethical problems in the management of severely ill, handicapped babies. He reviews 20 with such conditions as severe spina bifida with paraplegia who develop meningitis; severe mental defect with a surgically remediable anomaly such as intestinal obstruction; and combinations of brain damage due to birth injury with spina bifida and meningitis. Of the treatment of these babies he asks four "important ethical questions":

1. Should life-saving measures be instituted?
2. Should this decision be made by the doctor alone?
3. Should the decision be made by the doctor after discussion with the parents?
4. Should the decision be left mainly to the parents?

The author recognizes the uncertainty a doctor must feel about the validity of the replies parents may give when he tries to elicit their views, and so their true feelings "had to be interpreted from flexible interviews designed to allow the parents to discuss freely their point of view." He found that in all cases but one (from which conclusions could not be drawn) the parents hoped for "an early peaceful death" of their infant. But discussing with 13 sets of parents the question of carrying out life-saving treatment he found that five favoured and eight opposed active intervention. Four years after he had initially seen them Lawson again interviewed six sets of parents. They then expressed similar feelings to what they had before and "were pleased their infants had died."

Summarizing the parents' opinions in general, Lawson says it would seem that most would prefer their infant to die quickly and peacefully rather than live with severe handicaps, but they would rather not accept the responsibility for deciding their infant's fate. In considering the course the doctor should take, he writes that "in my opinion parents of these infants should not participate in the actual decision whether or not to implement treatment." With this view most doctors would agree.

While the complexity of treatment available today can make the taking of a correct clinical decision worrying enough, its efficacy can add to the doctor's anxieties rather than dispel them. To find a course that is ethical and humane as well as medically sound is part of the doctor's...
everyday practice, but the burden of having to consider the success of treatment as seriously as its failure is heavier than it used to be. “The health of my patient will be my first consideration,” states the Declaration of Geneva, and this injunction embodies a tradition with which every doctor trained in Britain, as in most countries, is made familiar from the moment he steps into the wards as a student. How best it should be fulfilled in some cases can weigh heavily on the doctor’s judgement, but an obligation must not be unloaded because it has become onerous.

Council and University

Though the universities are generally successful in appointing and promoting staff of high ability for research, they are apt to run into difficulties when allocating funds to one department or another. A report published by the Biochemical Society draws attention to this weakness in the conduct of their affairs, and its criticism doubtless extends beyond the limits of biochemistry. A dislike of favouring one individual or group in the university community at the expense of another is understandable. But the unfortunate result is a constant drag on the development of research, a preference for letting things go on as they are. In contrast the research councils, of which much the largest spender is the Medical Research Council, are better at picking out the winners and backing them heavily.

Such is one of the points made by the authors of this report, who with Sir Hans Krebs, F.R.S., as chairman composed a subcommittee of the Biochemical Society. They are impressed by the contribution made by the research councils to biological research in universities, which has been “outstanding,” and they are surprised to see “how much has been achieved with so little.” This view would find general agreement, as would another that the subcommittee expresses, which is that a teaching institution without research does not deserve to be called a university. But an important distinction between the universities and the research councils (though it receives little emphasis in this report) is the teaching which is the primary concern of universities. Unfortunately it is fashionable in some circles to speak of the “burden of teaching,” as though it were some kind of hack-work done to earn the bread-and-butter, a troublesome distraction from the real business of living—namely, research. But in fact the universities are more and more bearing the responsibility of training tomorrow’s doctors, lawyers, engineers, agriculturists, and the innumerable technically and professionally educated people needed to run a modern state. And it is only too well known among the humble trainees that outstanding abilities in research and teaching are rarely united in the same person.

With their very different obligations from those of the research councils it is easy to understand the difficulties which, in the words of the present report, “universities face in making value judgements on the merits of competitive research proposals.” But the suggestion that they would benefit by receiving more advice than they do at present from external experts may be helpful.

Old Age, Nutrition, and Mental Confusion

In recent years more elderly people have been admitted to mental hospitals and more research has been done into the aetiological factors of mental illness in the elderly. Mental confusion in older people can be compared with the “fit” or convulsion in the infant, and it is essential to determine the cause of this distressing symptom. To the general practitioner the mentally confused elderly person presents a difficult problem, often made worse by his worries about the home background, the neighbours, and, if he considers hospitalization essential, the placement of his patient. Unlike his colleagues in hospital he will in many cases have intimate knowledge of the social circumstances, the clinical history, and the course of his patient’s illness.

Of prime importance in trying to determine what has caused the confusion are the speed of onset and any associated recent event such as bereavement. Confusion of sudden onset is almost always due to an acute infection such as pneumonia or a urinary tract infection and may or may not be accompanied by fever, leucocytosis, and a raised sedimentation rate. Patients who develop confusion on such occasions may well be on the borderline of mental insufficiency. The doctor should also review the patient’s present drug therapy, since the barbiturates, antidepressants, digitalis, and benzhexol are common causes of confusion. The history should exclude addiction to such toxic agents as alcohol or bring to light such previous operations as gastrectomy, while physical examination will reveal cardiac, hepatic, or renal failure, incipient cerebrovascular catastrophe, myxoedema, and probably the commonest causes of all—namely, distension of the bladder or faecal impaction. Mental confusion due to unsuspected or uncontrolled diabetes mellitus or from over-dosage of anti-diabetic drugs would be diagnosed after clinical investigation.

Inadequate nutrition might be suggested by the general appearance of the patient or by the dietary history, and this suspicion could possibly be confirmed by the findings of cork-screw hairs, petechiae, or sheet haemorrhages. While J. Andrews and his colleagues* reported that they were unable to confirm that sublingual lesions could be improved by supplementing the diet with vitamin C, these particular lesions were found on histological examination to be aneurysmal dilatation of the venules.

R. W. Strachan and J. G. Henderson* reported three cases illustrating a variety of psychiatric symptoms which might occur in avitaminosis B12 in the absence of subacute combined degeneration of the cord or of any abnormality of the peripheral blood and marrow, and they followed this with an account of two patients with advanced dementia who had megaloblastic anaemia due to folate deficiency. These findings make it essential to review the biochemical and haematological investigations necessary in undiagnosed mental confusion.

In last week’s B.M.J. F. Murphy and his colleagues* reported investigations done on 1,004 consecutive new patients aged over 50 admitted to a mental hospital. Assays of serum vitamin B12 led to the discovery of only two cases of pernicious anaemia, and this prompted the conclusion that such assays are not justified as a routine until fully automated techniques have become available. The incidence of pernicious anaemia found in their patients is slightly lower than that in a normal population of a comparable age group, 7 per 1,000. R. Shulman* reported the incidence of pernicious anaemia in