Chambers “In Principle”

The debating is over and the decision has been taken radically to change the B.M.A. (Supplement, p. 55). The temptation is great to hold a posturism on why the Representative Body somewhat brusquely brushed aside the Council’s compromise reform proposals1 2 in favour of Sir Paul Chambers’ sweeping changes.3 It should be resisted. Arguments that the decision was emotional or unrepresentative, that the agenda was at fault, that a business approach is unsuitable for the medical profession, or that it was the wrong time for such a massive shake-up may sound convincing and even perhaps contain some truth. But anyone present at the Special Representative Meeting last week must have noticed a determined mood for real change.

The approval by the Representative Body of a Somerset motion to accept the Chambers Report in principle was carried by the unequivocal majority of 70 to 30%. Furthermore, it was made clear—during the debate by the proposer and, after the decisive vote, by the Chairman of Council (Supplement, p. 58)—that acceptance “in principle” meant “the abolition of autonomy and the fact that a voice in the affairs of the Association in the future would be limited to its members.” Of course this decision creates many problems, for it cuts across not only the near-unanimous support in the Special L.M.C. Conference for the Council’s solution4 to reorganization but also the views of 90% of the regional committees for hospital medical services. But the committee autonomy and the B.M.A.’s accommodation of non-members were major targets for Sir Paul’s criticisms. He favoured a unitary rather than a federalist solution and the Council now has the task of translating his theory into reality. It may be hard pressed to do this work in time for the Annual Representative Meeting at Folkestone in June 1973 as is hoped. Apart from all the legal details to be sorted out the Council will wish to go to the R.B. with a plan that has the wholehearted support of hospital and general practitioners. If extra time is needed to reach that accord then the R.B. should grant it, for the eventual success of these reforms will depend on their being broadly supported throughout the whole profession. On the other hand, prolonged wrangling and delay would leave the B.M.A. vulnerable during a crucial period of N.H.S. reorganization.

There was little doubt about Sir Paul’s impatience with the constant internal compromises born of the B.M.A.’s complex committee structure. Admittedly, these complexities have not prevented doctors—either collectively or as individuals—exerting tremendous influence in the N.H.S. But most representatives clearly looked ahead with him to a strengthened administration in the integrated N.H.S. and wanted the strength of a truly integrated profession as a counterweight.

Time will tell whether the Representative Body was right on 15 November, but the deliberate appeal in the Chambers Report to younger doctors should attract their all-important support. The Association’s activities must command the confidence of the profession’s younger members and perhaps the S.R.M. rightly sensed that to discard Chambers would dismay them.

The recognition of a reformed B.M.A. as the negotiating body for the whole profession is vital. Indeed should this not happen then Chambers will have failed. The success or otherwise of the Association’s reorganization will depend on how the profession responds to it. If the R.B.’s views are widely representative its decision should stimulate membership and make the B.M.A.’s claim to represent all doctors virtually unassailable. There is no room for complacency, however. The Council and its committees face some extremely difficult decisions. At the close of the S.R.M. the Chairman of Council promised the Representative Body that he would not ignore the view of any group—large or small—and he pleaded that no one should take precipitate action. Anyone with the interests of the profession at heart will endorse this view, for it is essential that the profession should go into the reorganized Health Service with a strong, unified, effective, and fully representative organization.

1 British Medical Journal Supplement, 1972, 3, 51.
3 British Medical Journal Supplement, 1972, 2, 45.
4 British Medical Journal Supplement, 1972, 4, 45.

Family Size

According to the latest projections by the Government Actuary1 the population of the United Kingdom will rise from its present 56 million to 63 million in the year 2000 and 66 million in 2011. He sets out the many assumptions on which the forecast is based, and to many readers it will seem that getting within a million of the true figure is about as chancy as predicting the winner of the Grand National.
But he does draw attention in passing to an error that is apt to underlie discussions of trends in the birth rate.

Graphs are published from time to time showing the ups and downs of the annual birth rate, and we are familiar enough with the thought that today's crest may lead into tomorrow's trough. Fluctuations may be no more than ripples on a pond. This does not stop commentators from attributing a dip to a new contraceptive or a sudden flush of babies to an electricity failure. They may even be right, though chance might equally be the explanation. But what is less often considered is something much more important than the annual birth rate, and that is the size of completed families. For great changes in the birth rate are compatible with continuing uniformity of completed family size if many women decide to have children later, or sooner, after they get married, or if they increase, or decrease, the intervals between the births of their children. There is evidence that these factors have been at work and that despite falling annual birth rates in recent years the size of the families when they are ultimately completed will show little change. But the Government Actuary does forecast a slight reduction in accordance with present trends. A household survey has shown that women recently married expect to have slightly smaller families (average, under 2.3 children) than a comparable sample of women interviewed in 1967 (average, 2.5 children). But, since many thousands of pregnancies are still unintentional and the general availability of contraceptives, these expectations likely to be fulfilled?


Viruses of Vomiting

Next to acute respiratory disease, acute vomiting and diarrhoea is one of the commonest diseases in the community, though cases are rarely admitted to hospital. Much is known about those due to acute bacterial infections with shigelae and salmonellae and also to pathogenic Escherichia coli in infancy and in some outbreaks of travellers' diarrhoea. But other causes of such outbreaks of disease also exist.

An important study by J. Zahorsky in the United States showed that a disease that spread in families with a high secondary attack rate and was characterized by vomiting was occurring in his practice in the winter, when bacterial infections, common in those years, were infrequent. He called the disease "winter vomiting disease," and a similar disease was noted in Britain in families and in closed institutions. No pathogenic bacteria were isolated, and repeated studies, mostly unpublished, of such outbreaks have failed to show any viruses at all. Nevertheless the disease continues to cause trouble.

Pathogenic bacteria are not grown from many isolated cases of diarrhoea and vomiting in children, and these might represent cases of winter vomiting disease. Many viruses, particularly enteroviruses such as echoviruses and Coxsackie viruses, have been isolated in tissue cultures and animals from gastroenteritis in infants and small children, but wherever the same amount of effort was expended in isolating viruses from a matched group of children without the disease nearly the same proportions of the same viruses have been isolated. This is a slight exaggeration, for a rather higher proportion of certain viruses such as enteroviruses and adenoviruses have sometimes been observed in sick children, and occasional outbreaks have occurred in which gastrointestinal symptoms were associated with infection with a single virus from these groups. But the most that can be concluded is that a small percentage of gastroenteritis cases were due to the viruses isolated.

Yet there has been evidence for years that cases of gastroenteritis are due to virus infections. Faecal extracts from adult cases were passed through bacteria-tight filters and caused typical disease when given by mouth to volunteers. Sometimes the volunteers were not strictly isolated, sometimes they were. Moreover there appeared to be two types of virus, one causing a more severe disease than the other, and there was immunity to reinfection with the same virus but not to infection with the other one, suggesting that they belonged to distinct serotypes.

The Public Health Laboratory Service set up a committee to work on the problem about 10 years ago. It studied selected outbreaks in schools and found that only faeces transmitted the disease to volunteers. These workers transmitted the disease serially, and in collaboration with workers at the Medical Research Council's Common Cold Unit showed that it had the clinical features observed in schools, namely, vomiting with some diarrhoea and fever. It thus received the name "epidemic vomiting." By filtration and other treatments they showed that it was due to a small ether-stable particle, and its properties were compatible with its being a picornavirus or parvovirus.

The results of similar studies in the U.S.A. were published at about the same time. The original material came from an outbreak of non-bacterial "gastroenteritis." Its effects in volunteers were described, and, as in Britain, a high proportion of volunteers seemed to be susceptible, though on re-exposure they were resistant. The properties were similar to those described in Britain, and in addition the agent seemed to be able to withstand acid treatment and heat at 60°C. These workers suggested it might be a parvovirus, but neither group can precisely identify the agent yet. Nevertheless the U.S. virus, Norwalk, produces a disease in British volunteers which resembles that produced by the local virus, and they may well be similar.

For much further progress to be made it is necessary to grow the virus in the laboratory, and in this respect the situation is tantalizing. Despite the trial of a variety of organ culture techniques which had been developed to grow the viruses of gastroenteritis of animals the human virus failed to grow. Now after a lapse of some years well-characterized virus-containing material is again under study. We know more about these viruses than we did, and new techniques for growing viruses from the gut are appearing. Consequently progress is possible in a way that will open this virus to study in detail and so elucidate the disease it causes.

These diseases may interest other specialists beside those in communicable diseases. Preliminary studies on American volunteers have shown that they had transient depression of absorption of D-xylose and fat and rather longer lasting failures of lactose absorption, apparently due to lactase deficiency. It would be of interest to unravel the reasons for these changes. Does the virus destroy epithelial cells or interfere with enzyme production or absorption in a more subtle way? Such a change might be important in a child or adult in a malnourished state or in an underlying malabsorption disease.

A considerable proportion of children admitted to hospital