National Health Service Act

SIR,—Whereas most of us formerly favoured a national medical service, many of us now reject the scheme which has been offered in its place. The Act is a political instrument, and the Minister's insistence on appropriating the goodwill value of practices indicates his desire for absolute power over the profession and thus over the citizens whom they serve.

Secondly, according to a recent issue of the *Journal*, the Minister rejected a suggestion that a learned judge should have power to reinstate a dismissed member of the proposed Service, justifying this by an analogy which ought not to deceive a child by its logic. So he rejects criticism and learned guidance. The really competent do not surround themselves with a screen of unassailable authority. Thirdly, the prime cause of medical progress is research (I call to mind radium, radiography, sulphonamides, penicillin), which calls for hard unspectacular exertions, and instead of back-room research we are offered the brilliant footlights of mere reorganization.

I am not impressed by the benefits which it is claimed would accrue from the proposed scheme, such as security for young doctors who never asked for it, an equal deal for all classes, abolition of alleged exploitation, rotas, holidays, closer collaboration of doctors, etc. These benefits have been strewn riotously all up the garden path to obscure the fundamental philosophy of the Act, which is, for better or for worse, the annihilation of the doctor's independence.—I am, etc.,

Leeds. LIONEL SUMMERFIELD.

SIR,—So much has been written in your columns concerning the National Health Service and the plebiscite that one would have thought the profession must be familiar now with most aspects of these matters. Nevertheless, it appears to me to be necessary to answer three of the letters in last week's *British Medical Journal*.

Dr. H. B. O. Cardew (Dec. 7, p. 873).—It is a favourite saying, but quite incorrect, that there is a clear mandate from the electorate to pass this particular National Health Service Act. There is a mandate for *a* National Health Service, and with that everybody agrees. The details of the present Act were not published to the electorate before the general election. In order to produce an efficient service it is not necessary to hedge the doctors about with a hundred and one distasteful conditions.

Dr. Lennox Johnston (p. 874).—There is no moral obligation as citizens to co-operate in putting into effect Acts passed without taking into account the views of those most closely concerned. The suggestion that the profession should take its "medicine" in a sporting spirit reminds one of the first whiff of the anaesthetic—"Now, now, this isn't going to hurt a bit."

Dr. B. Halley Stewart (p. 874).—The Act is law, and the Minister himself has no power to alter it or negotiate about anything that is specifically contained in the Act. Your correspondent assumes that the deputation would tell the Minister in unmistakable terms what it thinks of the Act. The Minister can have only one reply—to show them the door.

I should like to add that I consider myself as without undue bias and sympathize with some of the aims of the present Government. Nevertheless the actual methods whereby they are putting these aims into practice has placed a severe strain on one's good will.—I am, etc.,

London, E.14. M. GODFREY.

The Act and Ophthalmic Treatment

SIR,—Ophthalmologists have good reason to feel disturbed by the letter from Dr. Leslie Hartley concerning the Act and ophthalmic treatment (Dec. 7, p. 873). There is a real danger inherent in unbalanced planning as exemplified in the constitution of key hospitals. No case has been made out that the patient is to benefit, and scant tribute is paid to the many ophthalmic surgeons who have been performing really good work at the periphery.

Planners—and medical planners are no exception—are notorious in their portrayal of the perfect State which will evolve as the result of their efforts, but we should not let this blind us to the danger implicit in an ever-swelling bureaucracy and a concentration of authority in the privileged hierarchy.—I am, etc.,

Windsor. CHARLES TAIT.

The Hogben Test

SIR,—I willingly take the opportunity of conceding that my letter (Oct. 12, p. 554) was in error in one detail, in that Shapiro did not come to work with me in London until after Dr. Zwarenstein's 1933 visit. I do so the more willingly because he was assisting Dr. Zwarenstein as a not yet qualified medical student during the period to which the preceding paragraph of my letter referred, and may therefore have been less conversant than his senior with other relevant facts correctly stated therein.

In so far as my letter involved any reference to himself or to his laboratory, I submitted it to Prof. Crew for his approval. For a reason stated below, the fact that Dr. Zwarenstein does not now recall the several conversations in which I acquainted him with pregnancy urine tests carried out in my own laboratory by Bellerby has little bearing on the issue raised in my letter. In any case Dr. Zwarenstein was in and out of my laboratory for some months while the tests were still in progress and could scarcely fail to be aware of what was going on.

I do not think that the alleged independence of the work Zwarenstein continued at my instigation and with my encouragement after I left South Africa is an issue which would have occasioned dispute if the South African Press had not boosted the use of *Xenopus* for pregnancy diagnosis as an indigenous South African discovery. This was why a former Capetown colleague, prompted by its local publicity and a forgivable zeal for the credit of South African science, brought it before the attention of readers of this *Journal* (1939, **1**, 1258). That he then had the last word was the outcome of a personal letter in which he admitted intervening without full knowledge of the facts and expressed the hope that I should be satisfied with a face-saving gesture on his part. I did not care to embarrass a friend by protracting the controversy to comment on one remark which is of special relevance to the dispute. Since circumstances have changed, I can now do so.

My discovery of ovulation induced by anterior lobe extracts with gonadotrophic activity was an unforeseen by-product of work on chromatic behaviour suggesting the possible identity of the *w*-substance of Hogben and Slome with the gonadotrophic hormone, hence also its equivalence to the gonadotrophic autacoid in the urine of pregnant women. If this view were correct the latter would evoke both ovulation and the white background reaction, either of which would then serve as an indication of its presence in urine. If it were (as it is) incorrect the gonadotrophic component of urine from pregnant subjects should evoke ovulation without evoking the white background reaction.

Prof. Gunn's final pronouncement (*British Medical Journal*, 1939, **2**, 580), after correcting statements made in all good faith in his earlier one, includes the following:

> "Prof. Hogben refers to pregnancy tests which, on leaving Capetown, he had entrusted to Drs. Ariel Goldberg and David Slome. I am informed by Dr. Goldberg and by Dr. Zwarenstein, *who actively assisted in these experiments* [italics inserted], that numerous tests were carried out during January and February, 1931, in the physiology department. The observations were made, however, *not on ovulation* in *Xenopus* but on colour changes in the skin."

That Prof. Gunn made in all good faith the last remark here printed in italics [inserted] is beyond question, since he freely admitted that he had no first-hand knowledge of the circumstances attendant on the discovery that *Xenopus* ovulates overtly in response to the gonadotrophic hormone. Seemingly neither Dr. Goldberg nor Dr. Zwarenstein disclosed the fact that they never reported the results of such tests for my comment. If this was because their samples failed to evoke ovulation as well as to evoke the more delayed full *w*-response, the so-called captivity effect (i.e., defective care of the test animal) furnishes a sufficient explanation of their failure. Seemingly the outcome convinced Dr. Zwarenstein that *Xenopus* does not respond by ovulation to pregnancy urine. What is clear is: (*a*) that he did not resume experiments on the effect of the latter until he had disclosed his belief that *Xenopus* undergoes ovarian retrogression in captivity, and then by recourse to freshly caught

toads; (*b*) the publication of the belief stated—one that he has not explicitly withdrawn—necessarily delayed publication of parallel tests in my London laboratory.—I am, etc.,

University of Birmingham. LANCELOT HOGBEN.

SIR,—I deeply regret the tone of the letter from Drs. H. A. Shapiro and H. Zwarenstein (Nov. 16, p. 752). Since 1930 I have been very closely associated with Prof. Hogben and colleagues in work on *Xenopus laevis* and well recall Dr. Zwarenstein's sojourn in London when Dr. Bellerby and myself were engaged on the work concerning husbandry and technique which was necessary before *Xenopus* could be introduced as a reliable test animal for general use.

It is beyond question that the test arose from Hogben's discovery in 1929 that *Xenopus* ovulates in response to pituitary extracts. Under Hogben's leadership a thorough exploration of the implications of this discovery took place between 1930 and 1939, when the general applicability and reliability of the test were fully established. Prof. Crew, himself entirely familiar with the whole of the research in this field, very properly termed it the Hogben test.—I am, etc.,

University of Aberdeen. F. W. LANDGREBE.

*** This correspondence is now closed.—ED., *B.M.J.*

Milk Priorities

SIR,—The medical profession have been asked to co-operate in the fairer distribution of milk supplies. In my work at infant welfare centres I have been struck by the fact that proprietary milk foods are not on the milk ration and can be bought at a chemist's or welfare centre on presentation of a baby's ration book. The mother of a baby entirely fed on such a food can also, if she wishes, get one pint (568 ml.) of liquid milk daily on the baby's ration book and one pint on her own.

While it might be admitted that this mother needed an extra allowance to make up for the extra strain of pregnancy and lactation, it can hardly be necessary for her to have two pints, nor indeed one pint, for longer than a month or so unless she has some other condition which will qualify her for it separately. Under present arrangements a family may get two extra pints of milk daily where the baby is fed on a proprietary food. I have also known cases where a proprietary food has been bought ostensibly for the baby but actually used for making cakes—a thing which would not happen if the former were on the milk ration.

National Dried Milk, on the other hand, is supplied by the food office instead of liquid milk. I suggest that this arrangement be extended to all dried milks specially prepared for babies. It should not be difficult to issue cards in place of the present rationing slips, which could be used anywhere to obtain these foods. Such a scheme need not, of course, include foods which are added to liquid milk.—I am, etc.,

Birmingham. ELEANOR M. SAWDON.

SIR,—Surely in this question of milk certificates Dr. J. G. McDowell (Nov. 30, p. 834) is flogging the wrong horse. We have got to face the unpleasant fact that there is not enough milk being produced (in spite of the remarkable efforts of dairy farmers in the face of negligible imports of cattle food, which, I believe, is linked with the world shortage of fats) to supply the increased demand of the population. Dr. McDowell, as a preventive medicine specialist, can judge better than most of us whether or not it is wise to stint the general population for the benefit of invalids.

Incidentally, did the Minister of Food slander the medical practitioner? From what I remember of the report of his speech he merely made a statement of fact—that the milk going to priority consumers had risen about 50% in 18 months, and in view of the shortage of milk he asked doctors to review their milk certificates and place a stricter criterion on the necessity for extra milk. And, Heaven knows, it is easy enough to give certificates under II (*a*) or (*c*) for the majority of one's patients without putting too great a strain on—I was going to say one's conscience—but perhaps one's interpretation of the regulations would be better.—I am, etc.,

Langport. M. J. INGRAM.

Milk and Medicine

SIR,—Any doctor with a busy practice who has an inclination towards the State control of medicine should ponder over the recent dictatorial action of the Food Minister in cancelling all milk permits on Nov. 30. The result has been that for the last week I, like most G.P.s, have been inundated with applications for renewal of milk certificates, with all the consequent waste of time this entails.

Medicine is rapidly deteriorating into form filling—a grim warning of things to come unless we decide to unite and fight against control from doctrinaire politicians.—I am, etc.,

Croydon. GLYN JAMES.

Dicoumarol for Coronary Thrombosis

SIR,—In "Any Questions?" (Dec. 7, p. 882) there is a note on dicoumarol for coronary thrombosis. The advice given is "... 300 mg. dicoumarol are administered orally in one dose. This dose is repeated daily until the prothrombin time is 30 seconds. Doses of 100 or 200 mg. are given daily when the prothrombin time is between 30 and 35 seconds; above this level the dosage should be discontinued owing to the risk of haemorrhage."

The prothrombin time after a dose of 300 mg. dicoumarol does not begin to alter for 48 to 72 hours; it is possible to seriously overdose a patient by giving 300 mg. daily until the prothrombin time increases to 30 seconds. A much safer procedure would be to give 300 mg. daily for two days then stop altogether; it will be found that the prothrombin time will begin to rise about two days after the second dose and will continue to rise for three or four days, then will gradually decline, the base-line of prothrombin time being reached in approximately ten days after the first 300 mg. dose. When, by daily prothrombin time estimations, which are essential, it is found that the maximum time has been reached and the "days are shortening," a further small dose of dicoumarol may be given. Often 50 mg. is enough to increase the prothrombin time to the maximum after 24 hours; the patient at this stage reacts much more quickly. Still being guided by a daily prothrombin time estimation, further single doses of 50 mg. or 100 mg. may be given at irregular intervals; at this stage a daily dose is seldom necessary.

If for some reason the course of dicoumarol is stopped for some weeks or months, and then it is desired to resume it again, dosage must be very cautious. The patient may react rather violently and with unusual rapidity to doses as small as 50 mg. —probably 25 mg. is safer. It is true that little has been written on this subject in England, but the drug is being used and is very effective and only dangerous when the rather marked time lag between dose and effect is neglected or prothrombin times are not used as a guide. It is necessary to standardize the technique for prothrombin estimations and not to vary the method as results are all relative.—I am, etc.,

Epping. FRANK MARSH.

Colonial Medical Service

SIR,—In my early years in West Africa I encouraged qualified friends, who had thoughts of going abroad, to join this Service, of which I am still a member. Recently I have been a less active propagandist. This month a report by a Commission on the Civil Services in West Africa has been published. *If* its recommendations regarding salary and service conditions for medical officers are accepted, and *if* the implications of these conditions are made known to intending recruits, I doubt if any sensible young medicals will sign on the dotted line.

Before the 1935 reorganization of service conditions administrative and most technical officers began at £400 or £450 per annum, and rose to either £920 or £960 per annum plus a non-pensionable seniority allowance of £72. The medical officer began at £660, reached £960 plus £72 in ten years, and, after a three years' halt, went on to receive £1,150 plus £100 at seventeen years. In 1935 the maximum of *all* these salary scales was consolidated at £1,000. The medical officer, apart from dropping £250 on his maximum, was now to do three years' probation without an increment and to take thirteen years to reach £1,000. From his third year onwards his salary