which calls for these same qualities of physical endurance required by the men and women in the fighting and auxiliary services, and for no other reason than archaic sex prejudice in high places. I do not suggest that women should replace men as battalion medical officers, but there must be many administrative posts which could be filled by women, and certainly the demands of the members of the auxiliary services for women medical officers should be met. One anticipates with interest the report of the Committee on the Allocation of Medical Man-power which Mr. Brown has promised will be published shortly.—I am, etc.,

Tutbury, Staffs, March 3. MARY E. COCHRANE-DYET.

Vision Standards for Grading Recruits

SIR,—I have found the following details of such great service in saving time and worry that I thought other examiners might find them useful:

	R.E.	L.E.
Grade I Standard I: Unaided vision	6/6	6/6
	6/6	6/9
	6/9	6/6
Grade I Standard II: Unaided vision	6/9	6/12
	6/9	6/9
	6/12	6/6
	6/12	6/12
	6/12	6/9
	6/6	6 12
	6/6	6/18
	6/6	6/24
	6/6	6/36
Grade I Standard III: Unaided vision less than II but vision can be corrected to at least Standard II. If below 6/60 either eye—specialist. All men not placed in Standard I, II, III, refer to specialist.		
Grade I Standard IV: Unaided vision is less than II but vision cannot be corrected to Standards I or II but can be corrected to	at least 6/12 or 6/36	at least 6/36 6/12
	6/18	6/6
	6/24	6/6
	6/36	6/6
	6/9	6/18
	6/9	6/24
	6/9	6/36
	6/18	6/9
	6/24	6/9
	6/36	6/9
	6 12	6/18
	6/12	6/24
	6/12	6/36
	6/18	6/12
	6/24	6/12
	6/36	6/12

	R.E.	L.E.
Grade II (a) vision Standard V: Vision can be corrected to at least 6/24 in each eye.	6/18	6/18
	6/18	6/24
	6/24	6/18
	6/24	6/24
Grade II (a) vision Standard VI: Vision in one eye, with or without glasses, is not less than 6 12 and in the other is less than 6/36 with or without glasses, or has been practically lost.	6/6	6/60 or less
	6/9	6/60 or less
	6/12	6/60 or less
	6/60 or less	6/6
	6/60 or less	6/9
	6 60 or less	6 12
Grade IV Standard VII	6/18	6/36
	6/18	6/60 or less
	6/24	6 36
	6/24	6 60 or less
	6/36	6/18
	6/36	6/24
	6/36	6/36
	6/36	6/60 or less
	6/60 or less	6/18
	6/60 or less	6/24
	6/60 or less	6/36
	6/60 or less	6/60 or less

—I am, etc.,

West Kirby, Feb. 26. A. STANLEY PARKINSON.

"Give Us the Tools"

SIR,—"The general practitioner is the backbone of the country's health services" . . . we know that. We have heard it a thousand times, almost *ad nauseam*. The infantry is the backbone of the Army, but do we send our infantry into battle armed with bows and arrows? Somebody, the infantryman himself, would have something to say about that! Yet the general practitioner, having been trained in his school to the use of the technical developments of medicine which are in routine use, is sent out to fight in practice with a little leather bag! Oh yes! He can certainly obtain the advice and help required for his patients from the specialists and the hospitals, but he himself is barred from the fun of the game, and from exercising the skill and knowledge he acquired during his years of training and in his hospital appointments. In time, through lack of familiarity, the laboratory and the *x*-ray department become to his mind either awe-inspiring concerns which, like the slot machines, deliver ready-made diagnoses in return for hard cash, or they seem unnecessary and cumbersome complications of the modern machine-mad world. Some of his patients do not come back to him; some regard him as only fit to treat the minor disorders, not the real illnesses. Hence, after a few years of struggle and an increasing sense of frustration, many give it up, and really do become doctors only fit to treat the most minor disorders; and who can wonder at it?

The statement that clinical sense and not the laboratory aids reigns supreme in medicine is just reactionary nonsense *if* it implies that the aids to diagnosis are luxuries with which the "good practitioner" can dispense. The practitioner can perceive anaemia, discover glycosuria, hear a cough, record fever, and suspect cystitis. He can feel the irregular irregularity of the pulse, but he often cannot make the diagnosis without the aid of the laboratories and other special departments. But instead of having direct approach to these essentials he has to refer his patients to the specialist at an out-patient department at a hospital! The evils resulting from this are progressive. It is a serious thing if the backbone of the medical profession suffers from osteomalacia!

The system is bad, too, for the specialist, who has to deal with a glut of easily diagnosable disorders (given the necessary facilities), and cannot devote enough of his time to the few cases which really call for his skill. Anyone who has seen rows and rows of patients on hard benches at the hospitals will pity both the unfortunates sitting there and the physician or surgeon who, somehow or other, has got to "get through them." Finally it is bad for the patient, and medicine exists for the patient—not vice versa! He wastes time, and time is vitally important to the working people—so important that many will not report to their doctors or attend the hospitals until they are seriously ill, when curable disorder may have become incurable disease. Furthermore, it cannot be good psychologically for the patient to lose confidence in his doctor and go for treatment to the hospital.

The logical remedy for this state of affairs is apparent. The practitioner must have direct approach to the more common aids to diagnosis. I don't want to equip my infantryman with a tank: the specialist handles the tank, just as our specialists handle the cysto-, gastro-, and bronchoscopes, need calcium balances, and employ bone marrow investigations. But he must have a bayonet, a grenade, and a tommy-gun: he must have immediately available blood counts, blood ureas, blood sugars, sedimentation rates, sputum tests, microscopical and simple cultural examinations of the urine and faeces, and there must be an *x*-ray plant with a competent radiographer and radiologist, and possibly an electrocardiograph, at his service. And just as the Army has its Service corps, so should the practitioner enjoy the services of a trained nurse who could collect and examine specimens, take and record weights, prepare and sterilize instruments. The doctors should shut down their surgeries at their houses. They should be grouped together at a building where all these facilities are available. Here, too, would be their minor operation theatre, their mess-room, and their library. Co-operation and discussion would raise the standard of professional achievement, and those on the councils who deal with health problems could learn at first hand what the doctors need. The bad old times of "everyone for himself and his little leather bag" must go. And they will only go if the younger, more alive members of the profession, including medical students, residents, and the men in the Services, clamour and demand that they shall go. We must make a vociferous nuisance of ourselves that we may be given the tools with which to work. Only with the tools can we accomplish our task.—I am, etc.,

London, S.E.13, March 6. E. MONTUSCHI.

Mobile Unit in Action

SIR,—Your correspondence recently has revealed such a wide diversity of opinion regarding the utility of mobile first-aid units that I am prompted to contribute our experience.

Our particular unit has been called out to ten incidents, and has treated over fifty casualties—not many perhaps, but it is in the quality rather than the quantity of our work to date that its chief merit resides. Our casualties almost without exception have been trapped under debris for periods varying from one to nine hours. We have been able to improve their chances of survival by: (1) our facilities for shock and wound treatment while they were trapped and after they were rescued; (2) proper supervision of the final stage of the rescue operations, ensuring by accurate diagnosis and appropriate precautions that neither their injuries nor their shock were aggravated