with Government departments (who can be expected to have delusional ideas) but also in the profession itself.

Our real medicine is in the home and consulting-room, with the hospital providing a useful ancillary service, particularly in the field of surgical procedures. We should seek to be competent in our own field, and the hospital doctors might then, perhaps to their surprise, find we can provide a useful ancillary service to them in the instances where they are playing the leading part in treatment. Dr. Lane knows perfectly well that the vast majority of his patients never go near a hospital, and his real skills are applied to these and not those he sends into hospital.—I am, etc.,

R. A. GOULD.

Cowplain, Hants.

SIR,—Dr. K. E. Lane (1 March, p. 571) has made a timely and important point when he protests against the closure of general-practitioner beds in cottage hospitals and the failure of hospital boards to open general-practitioner wards in general hospitals. I would certainly like to associate myself with his protest, though, concerning the place of the general practitioner in the hospital service, as long ago as 1964 I wrote,[1] "It is beyond the scope of this paper to discuss why so many young doctors should want to emigrate, but a number to whom I have spoken have expressed it as their belief that the divorce of the general practitioner from the hospital, and the gulf which has developed between consultant and general practitioner in their ways of work, are in considerable measure responsible." This same view was expressed and amplified more recently in your middle article by Drs. E. O. Evans and E. D. McEwan (18 January, p. 172).

One is conscious, as a general practitioner, of one's responsibility towards the type of patient who requires cottage hospital care as quoted by Dr. Lane, but one would lay special stress on the need for care of terminal cases for whom room can never be found in acute medical and surgical beds, and for whom a geriatric unit may be some considerable distance away. No patient needs the care and attention of his family doctor more desperately than the patient who is beyond therapeutic aid, and the ruthless closure of cottage hospital beds on economic grounds ignores the basic needs of these unfortunate people. I think that Dr. Lane is a little modest in the number of beds he suggests that general practitioners might need. One bed per 1,000 patients on the list would, for an average list, only represent 2·5 beds per practice, or, in other words, just over one bed for each sex, which in a country district I think would be inadequate.

As one who has enjoyed the autonomous control of general-practitioner beds in a cottage hospital for some twenty years I feel that if these are removed from general practice the very basis of family doctoring as a worthwhile calling will be gone. I certainly would forgive any young man for emigrating from a country which is unable to offer him these or similar facilities.—I am, etc.,

Crickhowell, Brecons. R. C. HUMPHREYS.

REFERENCE

1 Humphreys, R. C., *J. Coll. Gen. Practit.*, 1964, 7, 402.

SIR,—I wish to congratulate Dr. Alan Porter on the clear, unemotional way he expressed his "Personal View" (22 February, p. 504) on the problem of general practitioners' inpatient care in district general hospitals. It is a concept that has received support from the Platt Report on hospital staffing[1] and the Gillie Report on the fieldwork of the family doctor,[2] but there is little evidence that the department has taken the recommendations seriously, and, at a time when only 3% of general practitioners are under 30 years of age and less than 14% are under 35, and when, for the first time, the number of doctors in the hospital service exceeds those in general practice, then something must be done quickly to reverse this trend. Dr. Porter does right to speak up for the "two large silent bodies of doctors" (those who have emigrated and those junior hospital doctors who dismiss general practice as a career), and I am convinced that the non-availability of hospital beds to general practitioners in the N.H.S. has been a major factor in their deciding their future. In fact, the only worthwhile conclusion made by the Ministry of Health Interview Board to North America[3] was, "The appreciation by the general practitioners [in North America] of their ability to use the hospital and participate in the care of their patients there cannot be exaggerated . . . that is the *chief factor* in deterring him from seeking to return to general practice in the United Kingdom" (my italics).

The nettle we are frightened to grasp is this vexed issue of determining *how* the general practitioner is to have clinical responsibility in the hospital. Unless a very clear plan can be evolved detailing exactly how a group of individualistic general practitioners can be slotted into the disciplined, hierarchical structure of a modern hospital, then the concept will remain a pipe-dream. The problems of human relationships with consultants, hospital junior staff, nurses, and administrators can be formidable, and it is easy to understand why the hospital should resist the entry of general practitioners when this would confer no obvious benefit to it.

But the winds of change are beginning to blow, and some hospitals are realizing that they are not "islands of therapy" unto themselves but that the standard of medicine practised by the general practitioners in that district will influence considerably the standard of medicine practised in the hospital. I know of a number of hospitals of district general status that are currently offering inpatient facilities to general practitioners, and I am about to conduct a comprehensive survey of all U.K. hospitals which have either established or experimental schemes or are planning such schemes.

I should be most grateful for further information of such hospitals if any doctor associated with the scheme would care to write to me.—I am, etc.,

N. A. SILVERSTON.

Bottisham, Cambridge.

REFERENCES

1 *Medical Staffing Structure in Hospital Service, Report of Joint Working Party.* H.M.S.O. London, 1961.

2 *The Field of Work of the Family Doctor, Report of the Subcommittee of the Standing Medical Advisory Committee of the Central Health Services Council*, H.M.S.O. London, 1963.

3 Report of Ministry of Health Interview Board to North America, *Brit. med. J.*, 1968, 1, 45.

Review Body Award

SIR,—The recent findings of the Cornmarket Salary Unit were reported in the *Financial Times* of 12 November 1968, and may be of interest to Dr. R. J. Stabler (8 March, p. 645) and others.

This survey showed that the true cost of living for professional people has been rising at the rate of 7–8% per year over the past four years. This estimate was derived from a basic rate of 5% per annum, plus "inflationary factors affecting junior and middle executives, such as the exceptionally high cost of mortgage finance, the increases in income tax, and rises in selective indirect taxes like petrol and road fund duty."

One hopes that Dr. Stabler has found some way round these afflictions of the junior and middle executive. Otherwise he has received an even larger negative pay rise than he thought.—I am, etc.,

M. C. BARTLETT.

St. Bartholomew's Hospital, London E.C.1.

Points from Letters

Eradicating Smallpox

Dr. A. BARLOVATZ (Kisangani, Congo Republic) writes: Dr. P. Dorolle (28 December, p. 789) errs when declaring the fighting of plagues impossible before all countries have become as affluent as Britain or Switzerland. The stamping out of smallpox over the whole accessible earth is well within the present financial means of the World Health Organization. As there are no animal vectors, it suffices to vaccinate successfully nine persons out of ten in the endemic parts of the world. This can be achieved by flying squads touring these districts every second year. One squad, consisting of a medical assistant, trained male nurse, or laboratory assistant, one still-less-trained helper for cleaning arms and putting vaccinees in rows, a third one for stamping and dating cards, and a driver able to do minor repairs, could easily inoculate 1,000 persons per day, or 300,000 per year.

Names and Words

Dr. PAULA GOSLING (Eastbourne, Sussex) writes: Dr. Philip Jacobs (1 March, p. 570) is to be congratulated heartily for his attack on the all-too-widespread use of eponymous names for diseases which plays a not inconspicuous role in the increasing difficulty of communication between different specialties. (Moreover, many of these eponyms, such as the Jacob-Creutzfeldt syndrome discussed in the same issue, are confoundedly difficult to spell and worse to pronounce.) I wonder how many doctors outside the relevant specialties could readily identify the disorders commonly labelled as Wolf–Parkinson–White syndrome, Besnier's prurigo, Osler–Weber–Rendu disease, Behçet's syndrome, Whipple's disease, Gilles de la Tourette syndrome, Scheuermann's disease, Parrot's pseudoparalysis, Heine–Medin disease, Niemann–Pick's disease, Beswick's disease. . . . Even conditions well-known under another name are now being re-labelled with eponyms—for example, Down's syndrome for mongolism—heaven alone knows why, unless it is a form of one-upmanship to confuse the non-specialist. If we *must* have these wretched eponyms used in articles, surely it should be obligatory for the authors to define their terms before they proceed to blind us with science or statistics.