perhaps unduly pessimistic in their conclusion that such evidence is never likely to become available. A randomised prospective clinical trial is not impracticable, and it would certainly seem desirable before embarking on a routine policy of nutritional therapy involving the daily administration of nitrogen, calories, vitamins, and trace elements.

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Anglo-American contrasts in general practice

SIR,—Good general practice is an entity which is difficult to define and quantify and Dr G N Marsh and his colleagues (29 May, p 1321) are to be congratulated on their excellent contribution to the subject. The general practitioner is subjected to numerous incentives and their effect is shown very clearly in their paper. The percentage distributions of all diagnoses made in ill patients (table VII) are remarkedly similar, yet in the American cases there is a strong bias towards examination—even over-examination—of their patients. In family planning consultations (table XIV) 77·7% of the patients in the American series had pelvic and 50% had rectal examinations, so at least 27·7% had both, which seems absurd since they were presumed to be healthy people. It appears that medicine there must not only be practised, it must be seen to be practised.

All medical procedures have a cost and a benefit and the requirement for their use must have some relation between their cost benefit ratio and the general standard of living. One might use the 10% abnormality ratio as a yardstick in this consideration. For example, if less than 10% of the routine chest *x*-rays one orders are abnormal it is quite likely that the investigation is being requested too frequently. Clearly when the investigation is cheap and convenient or its results of greater importance lower ratios are acceptable. On the other hand many GPs in this country dispense with, for example, the frequent use of the clinical thermometer since a pyrexia that is not clinically obvious is often unimportant. In any investigation a factor of human observation exists and the vigilance that ensures its efficiency is likely to be relaxed when the expectation of the abnormality is likely to be unduly low. Large batches of routine physical examinations on healthy people tend to be self-defeating for this reason.

Perhaps we should not ask ourselves what is good general practice. When the patient is satisfied it is sometimes at the cost of doctor dependence or even patient dependence. Perhaps we should ask ourselves what is effective general practice, and here we are on sounder ground. The GP casts a net and we should really be concerned with what is caught and what passes through and in this respect the paper, as the authors point out, is not very helpful to us. Despite wide variations in the manner in which the patients are investigated there is no evidence that the patients were any the better or worse for it. Clearly in America medicine is more visibly seen to be practised. What remains to be seen in whether it is more effective.

B JAMES

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SIR,—Working as I do in a health-centre-type practice in Belgium, caring for servicemen and their families of Britain and the United States and co-operating closely with our North American colleagues, I was interested in the statistics and conclusions quoted in the article by Dr G N Marsh and his colleagues (29 May, p 1321).

I should like to comment that, although we are dealing with a population in the age groups 0-60 years, after consultation with our US colleagues I find that the pattern of disease treated in this mixed community approximates more closely to that found in England than in Iowa. In particular, I find that the diseases mentioned as being more commonly found in Iowa owing to more intensive examination—that is, hypertension, otitis media, and diabetes mellitus—are not found more frequently by us, working as we do in an ideal general practice setting. I can only assume that perhaps the criteria for the diagnosis and treatment of hypertension may be different. In British practice diabetics tend to be cared for in specialised clinics, and if the low percentage use of the auriscope in cases of tonsillitis (first diagnosis) (21·4%) in England compared with Iowa (84·9%) is to be believed this could well account for the higher reported incidence of otitis media and, of course, confirm that Iowan doctors perform a more thorough investigation.

We have now been stimulated to compare the morbidity rates for the British and US communities more closely.

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Can geriatrics survive?

SIR,—Dr J C Leonard (29 May, p 1335) has written a provocative article and has done a service in bringing the misunderstandings of geriatrics by physicians into the open. Central to his arguments against the continuation of geriatrics as a specialty is his assertion that "the average age of the patients in many acute medical wards is probably not very different from that of those admitted to an acute geriatric ward." Furthermore, "every physician accepting general medical emergencies acquires plentiful experience in the medicine of old age." Such is the basis for his conclusion that "in view of the similarity of the acute inpatient workload there seems no justification for separate general medical and acute geriatric units. Physicians accepting a general medical intake . . . will be at least as competent as the staff of geriatric units to deal with acute illness in the elderly and assess elderly patients with long-term problems or who are brought into hospital for 'social' reasons."

These erroneous views appear to be held by many general physicians—the "we're all geriatricians now" school. It perhaps relates to careless use of the terms "old" or "elderly" for those over 65 while geriatrics mainly concerns the over-75 age group. The average age of those admitted to geriatric departments is very high, our own average of 79·5 years[1] being quite typical. In a study based on the geriatric department of the North Middlesex Hospital,[2] where I was formerly consultant, we showed highly significant differences in the age pattern of admissions between medical departments and the geriatric service. Of the patients admitted to general departments from a defined area, 29% of the 65-74 age group were admitted to medical departments and 24% to the geriatric department. In contrast, only 16% of patients over 75 went to the medical wards whereas 57% were admitted to the geriatric department. Admission statistics for Northwick Park Hospital for the first quarter of this year show a similar picture and allow a comparison to be made between my own experience as a geriatrician and that of my wholly NHS physician colleagues. On average, each of them saw rather more patients aged 66-75 than I, in the ratio 1·3:1. However, I saw five times as many over-75s and 15 times as many over-85s as they did.

I see quite a number of patients with cardiac, gastroenterological, or joint diseases and they see quite a number of elderly patients, but our experience is still strikingly different. They are no more "all geriatricians now" than I am a cardiologist, gastroenterologist, or rheumatologist. Their specialist skills and mine equally depend on our different special experience coupled with special training, study, interest, and commitment in our particular fields. Dr Leonard's outlandish criteria of what constitutes a specialty seem to me to be totally irrelevant.

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[1] Hodkinson, H M, *British Medical Journal*, 1972, **4**, 536.
[2] Evans, G J, Hodkinson, H M, and Mezey, A G, *Lancet*, 1971, **2**, 539.

SIR,—Dr J C Leonard's arguments (29 May, p 1335) were well holed above the water line by the consultants (12 June, pp 1464-66) who answered his question. May a general practitioner now explode the powder in the magazine?

Geriatrics has emerged not only because the elderly were not properly cared for heretofore but just as paediatrics developed from the demonstration by Ashby, Still, and Thomson that clinical efforts were frustrated without understanding biological modification by age. They did not wait, as Dr Leonard implied they should, until a firm foundation in clinical processes or unique techniques brought their specialty into being. They proceeded to uncover the basis of variant anatomy and physiology previously unrecognised in children as the basis of their clinical endeavours.

Now is Dr Leonard going to deny that since I qualified 25 years ago the most dramatic and revolutionary concepts in medicine have come out of geriatrics? Never mind whether it is difficult to recruit staff to it or whether beds are blocked in unenlightened places, for these are circumstantial and evidence only of a pervasive ignorance. I suggest, in passing, that a dearth of private patients, reluctance to grant merit awards, a reduced fear of litigation, and a lack of contact with the philosophy of the discipline are not insignificant pointers to the situation. However, one would be insensitive not to have felt such spurs at one time or another.

Since my first contact with a consultant in geriatric medicine I have been particularly observant at the bedside of older patients. I have learnt to examine the thorax from above, to feel the carotid arteries, to revise the precise location of surface markings of liver edge and apex beat in the presence of kyphoscoliosis. I have cursed the need to learn about geriatric

morphology, the altered signalling of common diseases, the need to recognise as normal things that were once always abnormal, such as loss of lower limb reflexes and vibration sense. My only comfort has been to see others, consultants in general medicine, flounder at the bedside like myself and conclude the consultation with the words, "I'll have to take him in"—but to a ward where no one had studied the height of beds and chairs and where the more abundant nursing staff got by with charm and kindness but could be seen dragging the stroke patient up the bed by the fulcrum of the axilla, watched by the ward sister.

I don't mind whether one specialty swallows another. I do not like to envisage a situation where dog eats dog. I would like to see everyone taught the principles now known about the management of elderly patients from the beginning of his career. General medicine has become rather old hat, and not to be trusted when 40% of surgery and home consultations are concerned with pensioners I am more afraid of making mistakes in patient management than of words to describe the specialty into which it might best be fitted.

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Echocardiography in mitral valve prolapse

SIR,—The echocardiogram published as part of the short report by Dr D Krikler and others (22 May, p 1257) is not diagnostic of mitral valve prolapse. In order to make a confident diagnosis of this condition from the echogram it is necessary that the anterior and posterior leaflets be displayed throughout the whole of the cardiac cycle and that the two leaflets shall be seen to come together at the beginning and the end of systole.

In the normal subject echoes from the two cusps can be separated in systole if the echoing point is not at the free margin of the two cusps which come into apposition (point A in the figure). If the echoes are derived from a position nearer the valve ring, such as point B, they will be separated in systole. During the course of echography it is possible, owing to the rotation of the heart about a horizontal as well as a vertical axis, for the transducer beam to move from point A to point B and back again. In order to be sure that all the echoes come from the free margin it is therefore imperative that apposition shall be demonstrated both at the beginning and the end of systole; unless these strict criteria are used over-diagnosis of mitral valve prolapse will occur.

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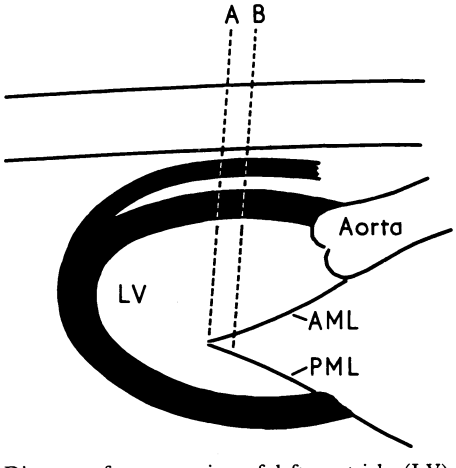

Diagram of cross-section of left ventricle (LV). A = Direction of an ultrasound beam in which anterior and posterior mitral cusps come into apposition at the beginning and end of systole. B = Beam position with separation of cusps. AML = Anterior mitral leaflets. PML = Posterior mitral leaflets.

Bites from black snakes

SIR,—Encounters between people and snakes, either accidental or provoked, become more frequent as the summer holidays bring people into the countryside. In the management of snake bite it is important to ascertain whether or not the snake was an adder, and it is said that adders can be identified by the bold V-shaped marks on their backs. The following case history may be of interest.

In May last year a 23-year-old man saw a snake in the New Forest and tried to pick it up. He was bitten on the left index finger. The snake was about one foot (30 cm) long and black, and the man, who had a keen amateur interest in snakes, was sure that it did not have the markings of an adder. A few days previously considerable publicity had been given to the discovery of an escaped tropical snake in a Southampton garden, and it was with this in mind that in the casualty department we gave the patient intramuscular hydrocortisone. Two hours after the bite the finger became inflamed and inflammation then extended to the entire arm. The resulting painful and grossly swollen arm necessitated the patient spending four days in hospital before it resolved sufficiently to permit his discharge.

Subsequent inquiry revealed that melanistic forms of adder are known, and are said to be particularly common in the New Forest. This, together with the severity of the reaction, leads us to conclude that our patient was bitten by an adder. We intend to treat any future bites from black snakes as adder bites.

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K J FOSTER

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Driving and medical fitness

SIR,—Dr G W Roberts (15 May, p 1210) expresses concern about the medical consequences of issuing driving licences valid to the age of 70 with three-year renewals thereafter. He mentions that the law now requires drivers to inform the Licensing Centre as soon as they become aware that they are suffering from any condition which may affect their ability to drive either now or in the future. Under the new rules there is of course no statutory obligation on doctors to notify the Licensing Centre, but doctors are asked to advise their patients about their obligation in this respect.

I can happily reassure Dr Roberts that his fears that the whole procedure would not work are in practice ill founded. Already during our first six months' experience with the new arrangements we have found that they are in fact working extremely well, thanks to the interest shown by clinicians both in general and in hospital practice. I am pleased to report that doctors are raising the question of driving with patients, who are in turn notifying their complaints in accordance with the new rules. The effective procedures which worked previously are continuing to operate and in fact are operating most successfully.

Dr Roberts makes the ingenious but I fear impracticable suggestion that health declarations should be made in relation to the annual licensing of vehicles. Registered keepers of vehicles are not necessarily drivers, nor are they necessarily related to drivers of the vehicles registered. It would be quite unreasonable to impose a legal obligation on these keepers to make inquiries into the health of drivers. Finally, Dr Roberts refers to the value of "an independent driving test." One of the improvements in the new arrangements is that driving examiners are no longer asked to make recommendations beyond their competence. The 1974 Road Traffic Act placed the responsibility to make recommendations in respect of fitness to drive in progressive medical conditions on doctors and not on driving examiners. Previously the examiner had been expected to assess the effect of disabilities on fitness to drive at the time of the driving test in complaints which could change dramatically subsequently—multiple sclerosis is a good example.

The implication in Dr Roberts's letter is that the matter of checking disabilities is left entirely to the discretion of the driver. But this is certainly not the case. Licences until the age of 70 are not issued to persons who are found to have medical disabilities relevant or prospectively relevant to driving safety. These persons have licences issued with a validity of one, two, or three years.

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Fits and fitness to drive

SIR,—Occasionally British journals would be well advised to adopt the transatlantic practice of the signed leading article so that readers can more readily gauge its gravitas. Your leading article (22 May, p 1235) on fits and fitness to drive epitomises the desirability of the signed presentation. It was clearly designed to be more authoritative than an annotation of the new edition of *Medical Aspects of Fitness to Drive*[1] yet is uneven in the treatment of the issues involved.

The presentation leaves one wondering whether in future these regulations will be applied automatically or whether there is a continuing need for expert medical judgment and the evaluation of specialist reports in determining the reliability of the evidence or, for example, in deciding whether a person with nocturnal status epilepticus can be considered safe to drive. There is the need for a straightforward explanation of the present laws and regulations, but this will fail to satisfy those closely involved with the medical problems of fitness to drive. We await a comprehensive distillation of the case experience of the medical advisers to the Department of the Environment so that the practicality of recent rulings may be adequately assessed.

One of the weaker features of the article is the apparent support for the empirical approach to improving seizure control by a casual increase in dosage or the addition of another drug. Wherever possible, medical