could be mounted on top of the tractor facing the driver (see Fig.).—I am, etc.,

P. C. M. SPARROW.

c/o New Zealand House,
London S.W.1.

Alopecia and Cytotoxic Drugs

SIR,—It has been my practice for a number of years to treat inoperable ovarian carcinoma with thiotepa (triethylene thiophosphoramide). I introduce 45 mg. in saline into the peritoneal cavity at the time of operation and subsequently give 300 mg. in divided doses intramuscularly, checking on the white cell count before each dose. Apart from leucopenia, I have never heard of any untoward side-effects until recently, although several patients have declared that the therapy made them feel extremely ill.

My most recent case, however, has lost a good deal of hair. Alopecia as the result of treatment with Endoxana (cyclophosphamide) is well known, of course, but I have not met it before with thiotepa. I would be interested to know if any of your readers have met this complication and whether it is something we must expect occasionally.—I am, etc.,

Manchester 3. WALTER CALVERT.

Pain and Alcohol

SIR,—Dr. W. E. Snell's letter on this subject (10 September, p. 645) evoked personal memories which may be of interest, since I am male. When I began to drink sherry in my late 'teens I used regularly to experience pain between the shoulder blades on taking the first sips of the initial evening glass. The pain was of a muscular aching character, only occurred with sherry, and gradually disappeared as the first glass was consumed. It continued to appear regularly for a number of years, but has long since ceased to afflict me, and was never sufficiently severe or prolonged to result in my declining sherry if there was no alternative on convivial occasions.—I am, etc.,

Ide Hill, Kent. J. P. CRAWFORD.

G.P.s and Hospital Beds

SIR,—I was pleased to see that Pertinax (6 August, p. 357) had been writing about the general practitioner and hospital beds, following on the article by Dr. John Fry in the *Practitioner*. It was primarily this aspect of the Health Service which prompted me to emigrate, as I found after six years as a general practitioner in England that I could never accept having to leave my patients at the hospital door, handing them over to other doctors who did not know them and whom they did not know either. I found on many occasions that this was difficult to explain to the patient; and could be very degrading, the patient realizing that I had no hospital privileges. Here in Canada it is understood that one cannot be a doctor without having hospital privileges and looking after one's patients in the wards or in the casualty department, with the aid of consultants as necessary. This leads to a much better relationship all round and certainly keeps one on one's toes.

I did not take the step of emigrating in haste, as I was always hoping something would be done about the general-practitioner services, but in the end my optimism was killed. But if I see any changes in the future I, for one, will be returning.—I am, etc.,

Winnipeg, Canada. G. P. STARCK.

REFERENCE

1 Fry, J., *Practitioner*, 1966, **197**, 143.

SIR,—Once more I see the cry for general practitioners to work in hospitals (Pertinax, 6 August, p. 357). To my mind both Dr. J. Fry[1] and Dr. K. Ball[2] paint a sad and unrealistic picture of general practice.

Medicine generally must be learnt in hospital, because it is useful to have teachers, patients, and students together at one time sufficiently often to learn the subject in a reasonable number of years. The whole of general practice is founded on accurate clinical medicine learned in hospital. However, on leaving hospital and entering general practice the medicine learned is then put into practice in the ordinary everyday world of the patients' environment.

In carrying out his job the general practitioner has a great number of technicians whom he uses—consultant physicians and surgeons, *x*-ray departments, pathology departments, chemists, and so on—but I cannot see that it is of any help for him to spend more working time in hospital than, say, in a chemist's shop. Obviously it is valuable to revise both medicine and pharmacy by attending these premises frequently, but his time is too valuable practising medicine in the world of the patient's environment to be able to work also helping his technical advisers.

If general practitioners can concentrate on the whole wide field of medicine as applied to the families in their care the pattern of general practice as found in this country can still be the most interesting and satisfying form that exists anywhere today.—I am, etc.,

Coxheath, Kent. H. C. H. BIRD.

REFERENCES

1 Fry, J., *Practitioner*, 1966, **197**, 143.
2 Ball, K., ibid., 1966, **197**, 163.

Appointment System in General Practice

SIR,—Dr. J. S. K. Stevenson's article (27 August, p. 515) is most valuable to those who, like ourselves, propose to copy him as soon as possible. But like Dr. Andrew Smith (17 September, p. 704) I cannot see that the patient needs to lose his personal doctor. Dr. Stevenson relies on emotion, not reason, only on that subject in his excellent article.

One partner and I share a consulting-room at fixed hours without appointment. Every patient knows which doctor he is going to see. An hour spent studying our records shows that the vast majority of patients always come to see the same doctor, and the only real exceptions to this are young people with minor ailments. The patient certainly wants his own personal doctor, and it is easier for the doctor to treat a patient well known to him than to plough through partners' notes, however well kept. I suggest that obviously the doctor's time is saved if he knows the patient, and surely his life is also pleasanter in this case. Must I be a "frock-coated anachronism" if I say that I like most of my patients? Patient and doctor are more sure of each other's good will, and lapses on either side are more likely to be forgiven. Perhaps those doctors who constantly complain have not given themselves time to make these friendships.

Six years ago we advertised for a partner and had 80 applicants for the post. About 10 of them were already in partnership but in a place where patients were seen by whichever doctor happened to be on duty. (In one town which is quartered by the crossing of main roads, each partner visited a different quarter of the compass every day. Apart from the attempt to ensure equal work for all four partners—surely useless—it is difficult to see the sense in this arrangement.) Those 10 young men all felt they were missing something important enough to be worth the major upheaval of changing practices. Will Dr. Stevenson say why they are wrong?—I am, etc.,

Sidmouth. G. H. GIBBENS.

Training for General Practice

SIR,—Dr. B. Wilson-Kay (3 September, p. 582) says that not only are compulsory training schemes unrealistic, but "also the schemes themselves." He refers specifically to the report on special vocational training of the College of General Practitioners.

I agree with his general theme that psychiatry is important in training for general practice—more widely important than obstetrics. But I am afraid that he misrepresents the College report, which recommends (*a*) six months of hospital appointments in obstetrics *with gynaecology*; (*b*) "at least three, preferably six, months" for psychiatry. It is correct that the report recommended no more than three months each for otolaryngology and dermatology.—I am, etc.,

London N.W.1. JOHN HORDER.

Phenylbutazone and Salivary Glands

SIR,—In your correspondence of the last months were several communications on salivary-gland enlargement and phenylbutazone. Dr. R. Wallace Simpson (9 July, p. 113) reported a further case, and added that he had been told that until 1962 no such cases have been observed. This is not correct. Hemming and Kuzell[1] reported in 1953 the first case of salivary-gland enlargement. In your journal Nassim and Pilkington[2] mention in 1953 a case with abscess formation of the salivary gland. Since then the salivary-gland enlargement has been a rare but well-known side-effect of phenylbutazone. I think that there is a relation between sialoadenopathy and the complaints of dryness in the mouth of some patients. There is nothing known about the pathogenesis of the phenomenon.—I am, etc.,

Baden, Switzerland. H. K. v. RECHENBERG.

REFERENCES

1 Hemming, A., and Kuzell, W. C., *Antibiot. and Chemother.*, 1953, **3**, 634.
2 Nassim, J. R., and Pilkington, T., *Brit. med. J.*, 1953, **1**, 1310.