few patients who might benefit from surgical procedures to improve their well being.

Bibliography

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Organic Causes of Impotence

Congenital: absence or fibrosis of corpora cavernosa
Traumatic: spinal cord injury, fractured pelvis, surgical (abdominal perineal resection, sympathectomy, cystectomy)
Vascular: priapism, arteriosclerosis (Leriche syndrome)
Neurological: spinal cord lesions, peripheral neuropathy
Endocrine: diabetes, hypogonadism
Pharmacological: parasympathetic blockade, sympathetic blockade

Letter from . . . South Australia

A Dean Down Under

PHILIP RHODES

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South Australia is a progressive state. It has a Premier who seems to be an intelligent intellectual. He heads a Labour government, which therefore has some accord with the central Commonwealth Government of Mr. Gough Whitlam. Our premier, Mr. Don Dunstan, known as "Donnie," is a lawyer who was able to devote an hour's television programme to poetry and his delight in it, and he recited it too. It was a great success. Recently he intervened in the Maslins Beach episode.

For many years Maslins Beach has been the haunt of illegal nude sun and sea bathing. The police had in general turned a blind eye or at most made an arrest when they had time from their other more arduous duties. The beach is about 20 miles (32 km) south of Adelaide and, like the whole long coastline, is relatively devoid of people. Then during a lull in the news the local paper started a story on Maslins. The police had to take some action and arrested a few offenders. Then a stipendiary magistrate, taking his duties seriously, announced that he would punish to the maximum the law allowed and gaol for three months those guilty of this heinous offence. Our Donni estepped in and the law was changed almost overnight. Nude disporting at Maslins became legal, and this was the first beach in Australia to be so licensed. Now there is also another.

After the brouhaha in the paper, cars blocked the road on the clifftop overlooking Maslins, apparently filled with people sporting binoculars and telescopes, and light aeroplanes, of which there are many, used the beach as a reporting-in station. The controllers of Adelaide airport are reputed to have played the game by allowing these daring pilots to come in to land at 500 feet (152 m). It was all less than a nine days wonder, though householders in the area became anxious that the value of their properties might fall. They obviously had little confidence that there might be enough voyeurs in the country to raise the asking price.

Community Medicine

Community medicine and community practice are all the rage in Australia. The Commonwealth Government is convinced of their value and has given generously of taxpayers' money to set up chairs of community medicine and health centres. Nevertheless, the Government, and many people, are confused about the difference between community medicine and practice. They make few distinctions. What they usually mean, when they appear to think about the problem at all, is family practice, or the delivery of primary medical care.

There is little understanding of the population as a patient, using the disciplines of epidemiology, statistics, and sociology. Perhaps community medicine is thought to be done by government teams involved in health care resources and is not seen as an academic discipline. This could well lead to confusion on the international scene since the holders of chairs of community medicine could well be general practitioners, so causing some difficulties in communication. But there are signs that the problem is being recognized and embarrassment may be avoided. Both disciplines are obviously needed but their aims are different, so it is well to keep some lines of distinction between them.

The teaching health centres in Adelaide are just getting under way, with Government support. They are superb. Purpose built and lavishly equipped, they are sited in shopping centres, which are the hub of life for small communities. The suburbs are spread out and nearly every house is on its own plot of land, so that the populace is relatively thinly spread. But nearly all have cars and the women in particular whizz in and out of the shopping centres, which cater for most of their needs. A health centre at St. Agnes is staffed by general practitioners whose consulting rooms are plush by U.K. standards. Wood panelling and carpets abound and the medical equipment leaves little to be desired. There is a room for a physiotherapist, a treatment room, and diagnostic radiological apparatus. Close by are dental services and a chiropodist. Behind the general practice suite is the consultants' suite, where visiting specialists come regularly. The pathology service is excellent and run centrally by the Institute of Medical and Veterinary Science associated with the Royal Adelaide Hospital. (I will say more of these on some future occasion.) The Mini vans of the I.M.V.S. are to be seen all about the city, labelled "Pathology Collection Service," bringing specimens to the institute.

Health centres are staffed, apart from the doctors, by nurses and secretaries, social workers, clinical psychologists, counsellors, and, indeed, all who nowadays are essential for the full delivery of health care. Visiting patients in their homes is being built up, and all who work in these centres are greatly enthusiastic, and this alone will ensure their success. The patients' reaction is harder to assess but seems very favourable. At the least they may be saved a long journey to a centrally situated hospital. The newer immigrants from Europe, however, are used to going to hospital for their primary care, for a variety of reasons, and

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possibly the health centres may not reach them. But even this is being taken care of, for major hospitals are developing in the suburbs too. The hospital near to St. Agnes is a short distance away at Modbury, and the two deliverers of health care are very closely linked indeed so that each is virtually a part of the other. Perhaps in time their governance, which is now separate, may merge.

The Professor of Community Medicine (properly defined) has been largely associated with setting up the teaching health centres and serves on the committees which run them. Medical students are enthusiastic about them and benefit from seeing and working in community practices, which show an excellent blend of private enterprise and government and university medicine. Moreover, the Modbury Hospital is a teaching hospital, so there is a nice integration of practice and teaching in a very modern setting. The research programmes are only just beginning, since the project is new, but their findings should be of value on a much wider stage. Their development will be interesting and watched with some concern.

Awkward Cases

What is to be done with the medical student who because of illness, especially of the psychiatric kind, seems unsuitable for a career in medicine? This awkward question has exercised deans of medical schools both in Australia and the U.K. A degree or diploma in medicine is almost certain to lead to registration after the prescribed period of residency in hospital. This, of course, gives the doctor certain statutory powers and the right to independent clinical practice. The independence and the access to patients are what may be the causes of concern, for the medical profession as a whole must take responsibility for protecting patients from doctors whose infirmity may cause them to act in any way dangerously.

Colleagues of a sick doctor in practice can usually prevail upon him to retire temporarily or permanently, or, in the last resort, there are the sanctions of being struck off or suspended from the *Medical Register*. A medical student who is sufficiently ill will, of course, be unable to continue his studies, but he may have emotional, even psychopathic, difficulties which scarcely affect his intellectual ability to pass the final examination and ultimately to be registered. In these cases the dean usually sees the student and, with his consent, arranges for him to consult the student health service and possibly a psychiatrist.

The prognosis may vary with the particular illness. Temporary leave of absence may be enough for the outlook to become clear, and the student may himself decide to abandon medicine. But a problem may arise if he insists on continuing when his suitability to be a doctor is in doubt. Who is then to determine his suitability? Who should take action and in what form? Obviously the dean must, taking the best advice available from colleagues, teachers, the health service, and the appropriate consultants.

The dean's power should probably be limited to suspending the student while the case is presented to the body finally responsible for the medical school or faculty. Ultimately this will mean the controlling authority of the university. These authorities are well used to deciding the academic suitability of students to continue with their course but they are less capable of making such decisions on other grounds. To avoid injustice they tend to be lenient, which in general is the only sensible policy. But academic authorities often leave out of account their wider responsibilities to the public and may ignore the concern of the medical profession for its members and for its prospective members.

In difficult cases like this we must perhaps realize the impossibility of having firm rules to cover every contingency and that it is essential to avoid injustice to individual students. The present mechanisms, informal in their earlier stages and flexible in the later ones, are probably the best that can be devised in the circumstances. The dean can wear his doctor's hat to begin with, marshalling his medical resources and modifying the course to suit the student as seems therapeutically appropriate, and only later need he change to his administrator's hat, which fortunately is only very rarely necessary.

Terms of Serivce

The state governments in Australia run certain hospitals aided by grants from the Commonwealth Government. They employ doctors on a sessional basis, the terms of employment being agreed between the Public Service Board and the Australian Medical Association. The senior staff are classed as visiting medical staff. A senior visiting medical specialist has to be a specialist on the *Register*. He is appointed for three years and is allowed up to five sessions a week, but no more without the express permission of the Minister of Health. The sessions are as in the U.K. Pay is at the rate of $2830 per annum per session (about £1625—that is, £8125 a year for five sessions). Slightly lower in the scale is the visiting medical specialist, who is paid $2230 per annum per session (about £1280 or £6400 a year for five sessions) and is appointed for one year. There are also senior visiting medical practitioners and visiting medical practitioners who are general practitioners. The seniors must hold a qualification of the Royal Australian College of General Practitioners or have had 10 years' relevant medical practice. The pay of doctors in these two grades is $2230 and $1715 per annum per session respectively. They are each appointed for one year.

After the expiry of their periods of appointment the holders of all the above posts are eligible for re-election, and usually they are re-elected. By British standards these are good rates of pay, since there is much private practice in addition. The coming of Medibank, however, may reduce the amount which can be earned in this way.

There seems to be an increasing move to full-time salaried medical service, though "full time" in this context may carry with it the right to earn up to 25% of the basic salary in private fees. The new Flinders Medical Centre is advertising for academic specialist clinical staff of senior lecturer or associate professor status at salaries between $15 685 and $20 683 a year together with the possibility of earning up to $5515 in addition in private practice. The basic salary may well soon be increased and it may be that the private fees will normally be earned within the hospital confines. At the top of the scale a senior lecturer's income may be £15 000 a year.

The cost of living here is about the same as in Britain. Taxation is just as heavy, houses are slightly cheaper, cars are slightly dearer, petrol is cheaper, food about the same. In the doctor's sort of income bracket there is no tax relief on mortgage payments. State schools are good. Private schools abound and cost a little more than equivalent British schools, and they are mainly for day pupils. Most of them are coeducational, though there are plenty of single sex schools.