appeared slowly within a few hours. 800,000 units of procaine penicillin intramuscularly did not cause any detrimental effects.

The second patient, a 24-year-old woman with severe myasthenia gravis of six years' duration, was also tested in a stationary phase of her illness when she had no superadded infection. 1.0 g. of streptomycin sulphate was administered intramuscularly. Her walking became distinctly more difficult in 15 minutes. After 20 minutes she was incapable of standing; after 25 minutes sitting and supporting her head was difficult; and after 30 minutes she became dyspnoeic, while the pulse increased to 150/min. She had to be carried to bed, where dyspnoea diminished and her condition improved, though an obvious and profound muscular weakness continued for about 10 hours. On the following day a placebo test was without any effects on her condition. The streptomycin tests were later repeated with similar reactions. Neostigmine and edrophonium antagonized the weakness clearly but incompletely.

These observations emphasize the importance of the right choice of antibiotics, especially for such myasthenic patients whose illness is severe and balanced only with difficulty.—I am, etc.,

The Neurological Clinic, Lapinlahti Hospital, Helsinki, Finland. EERO HOKKANEN.

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A View from Australia

SIR,—I have just had the pleasure of reading the issue dated 4 January (p. 50), in which the future of general practitioners in hospital practice was discussed by a meeting of the Royal College of Physicians, and I wonder if my experiences here would be of any interest.

I am the radiologist to the north-west area of Victoria serving a population of some 80,000 in a widely scattered district of at least 10,000 square miles. The largest town is only 20,000 and the medical care is in the hands of 23 general practitioners, of whom four practise as general-practitioner surgeons (having the F.R.C.S.), and an ophthalmic surgeon, an E.N.T. surgeon, a skin specialist, a pathologist, and a radiologist. There are a number of country hospitals with limited facilities, and the Base Hospital with full facilities. At none of these hospitals is there any resident medical staff, the duties being carried out entirely by the private practitioners. The great bulk of the medicine is, of course, private, with a limited 5–10% of public work.

My reason for writing this letter is to restate something which is of course obvious enough to anyone in general practice, but which is often forgotten by those in the higher reaches of the profession—namely, that an overwhelming percentage of illness is best treated by the patient's own personal doctor—that is, his general practitioner. With the aid of full ancillary services and with modern drugs, surely the number of illnesses which the general practitioner is not equipped to treat is few? I can see no earthly reason why the general practitioner should not treat patients with coronary artery disease, pulmonary infections, asthma, arteriosclerosis in its various forms, osteoarthritis, dyspepsia, and simple fractures (of which there are far more than complicated ones). I can well see that in many of these simple cases there will be times when the general practitioner will need to call in a consultant, but how much better for all concerned if the general practitioner undertakes the care of these illnesses.

From my reading of the discussion between the senior members of the profession I have the very definite impression that their view of medical practice is distorted in the sense that they believe the hospital service does not really need the general practitioner, but he could be fitted into some nook or cranny where he cannot do too much harm. I do not know if things have changed since I left the North of England, but in the early part of this decade the majority of the surgical registrars in the big cities were from overseas, and most of the emergency surgery was done by them; surely this is fundamentally wrong. This I know does not happen in the teaching hospitals, but it does happen outside, and I think any discussion which does not put this at the top of the list is pointless. What the Royal College of Physicians should be asking itself is not do we need them, the general practitioners, but how can we organize matters so that (1) we can do without the great numbers of foreign registrars we are using as cheap labour at the present time, (2) encourage general practitioners to do a period of training in a specialty before entering practice, so that they can fill the present registrar positions on a part-time basis.

This modern trend to increasing specialization is surely only a temporary phenomenon and is based on the false idea that medicine is a pure science. If we take out infective disorders the great bulk of illness is degenerative in nature, and for this all that the medical profession can do is to help the patient to live with his disabilities, and this must surely always be the job of the general practitioner.

I think that if there were any prospect of using their specialty in general practice far more doctors whose eventual aim was to enter general practice would be anxious to do two or three years' training in a specialty; but it would have to be made worth their while. Finally, I feel that payment by item of service is the only course which will encourage the doctor to do all he can, and not how little, and the Government made to think of the savings in terms of patients' time, hospitals' time, and the stoppage of the present drain of highly valuable doctors to the rest of the world—quite apart from a better service.—I am, etc.,

Mildura Base Hospital, Victoria, Australia. H. G. ROW.

The Australian Scheme

SIR,—I should like to offer a few comments on the letter of Dr. J. A. Jackson from Penrith, New South Wales (11 April, p. 986). He thinks that the Australian "modified N.H.S." satisfies all Australians. This is not so. I have just returned after working a year in two of the larger, more specialized Sydney hospitals. I am now in general practice here, and, although I have started too recently to offer a fair comparison, I can certainly view the Australian scheme dispassionately and see its faults. I am not suggesting the English N.H.S. is perfect (far from it), but I feel that unqualified praise of Australia might mislead potential immigrants.

The Medical Benefits Fund, about which Dr. Jackson enthuses lyrically, is not a perfect instrument for reimbursing medical services costs to patients. The refund is a variable proportion of the outlay, there are many exclusion clauses and invalidating circumstances, and there are heavy administrative delays. Many of the population are *not* insured and I had to deal personally with many patients discharging themselves before completing essential treatment simply because they could afford no more. No doubt they *should* insure, but it does not help pointing this out at trouble times. English compulsory contribution ensures full cover. The Fund pays no unemployment money (only medical costs), so if a wage-earner is sick and his employer will not pay him his family may be in great difficulties. Some people feel this is an incentive to work more and malinger less; others feel it merely adds extra worry to a sick person and slows his recovery.

Most essential drugs can be supplied to the patient for 5s., it is said, but there are many exceptions of what are, in my opinion, essential drugs; and strict limitations on the prescribable amounts of listed drugs.

Australian doctors can make a much larger income than can their English counterparts for the same amount of work. However, Australian patients tend to suffer financially much more than English ones, and I was not impressed that the scheme works so well that everyone was happy. I was very happy working in Australia and many of the medical points are very good, but if I was forced to choose between the Australian and the English schemes and not allowed to modify either, I would choose the latter. To prove my contention, I have returned at my own expense.—I am, etc.,

Birmingham 15. ANTHONY JOSEPH.

F.R.C.S.(Glasg.)

SIR,—A year or so ago when this College acquired its new name one of our first acts was to resolve that since we shall now confer a diploma of F.R.C.S. we must ensure that it will be demonstrably at least equal to that of other Colleges. We have now agreed that candidates for our examination be required to have undergone a four-year period of post-graduate instruction (three years in addition to the pre-registration year) with a precise but flexible programme of appointments in approved posts, including general surgery (or rotation posts covering general surgical experience), and optional periods in various specialties or in teaching or research departments.

This requirement is considerably more rigorous than that of other Colleges in this country. Moreover, as regards examinations, our primary is equated with others by reciprocity agreements and our final is, we believe, of equal standard. It has come to our notice that some hospital appointments boards and some overseas Governments still discriminate between the holders of diplomas of different Colleges. If they continue to do so I feel confident that in the future they will discriminate in favour of the holders of the F.R.C.S.(Glasg.).—I am, etc.,

CHARLES ILLINGWORTH,
President,
Royal College of Physicians and Surgeons of Glasgow.

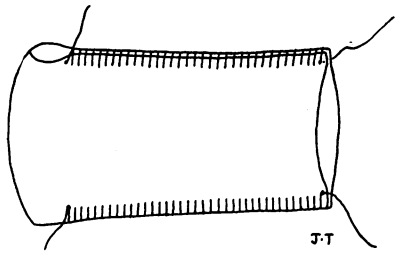
Glasgow W.C.2.

Arterial Replacement by a Double-width Vein Graft

SIR,—The following case is recorded not with any intention of claiming originality in the use of the method, for it must surely have been done before, but as a description of a quick and easy way of bridging a gap in an artery when a vein of sufficient diameter is not available.

A rather obese man aged 60, with a blood-pressure of 160/100, who complained of intermittent claudication, was operated on for occlusion of the lower third of the right superficial femoral artery. The occlusion was caused by thrombosis superimposed on atherosclerosis, the latter condition affecting the whole length of the superficial femoral and popliteal arteries. The upper two-thirds of the superficial femoral artery were cleared by thrombendarterectomy, while the lower third was bypassed with an autogenous, reversed saphenous-vein graft. Owing to medial calcification the disobliteration was not done cleanly, and on the following day both the disobliterated artery and the vein bypass were occluded by clot. The artery was reopened at its upper end and the clot extracted. A good peripheral circulation was achieved and the opening in the friable superficial femoral artery was closed with a vein patch. The wound became infected and 19 days later secondary haemorrhage occurred from the highest incision in the artery. On reopening the wound it was found that the haemorrhage was due to the lifting of one edge of the vein patch where the sutures had cut out of the wall of the disobliterated artery. The lifted edge was sewn back and the haemorrhage checked, but it recurred within half an hour and the opposite edge of the vein patch was found to have lifted. The patch was removed, the edges of the opening in the artery trimmed, and a "teflon" patch applied. Once more a satisfactory peripheral circulation was obtained.

The wound discharged pus after a few days but appeared to be healing until 30 days later, when once more arterial bleeding occurred from a sinus which led down to the teflon patch. Again the wound was reopened and the teflon patch, one corner of which had lifted, was replaced with a second vein patch. Haemorrhage recurred within a few hours and this time it came from a rent in the artery wall near to but separate from the vein patch. The thin and friable arterial wall was now no longer usable and was resected, leaving a 4-cm. gap in the upper end of the superficial femoral artery. Bridging this gap presented a problem. The upper half of the right long saphenous vein had already been used, and the left long saphenous vein was likewise unavailable since a disobliteration and bypass of the left superficial femoral artery had been carried out five months before. In the presence of active wound infection the insertion of a tube of synthetic material would have been unwise and the lower parts of the long saphenous vein were not wide enough to carry the necessary blood flow. It began to look as if the only way to deal with the repeated arterial haemorrhage would be by ligation of the superficial femoral artery, and the vascular surgeon's nightmare, amputation for claudication, loomed as more than a possibility. The problem was solved by excising an 8-cm. segment from the lower part of the long saphenous vein and cutting it open longitudinally. It was then folded across the middle of its long axis, endothelial surface inward, and the opposing edges sewn together so that a tube half the length and twice the diameter of the original vein, and closed at one end, was formed (see Fig.). The



closed end having been slit open, a channel with a diameter approximately equal to that of the superficial femoral artery was formed. The gap was bridged with this, a good peripheral circulation obtained, and with the help of antibiotics the wound healed by first intention, leaving the patient symptom-free and with a strong popliteal pulse.

I am indebted to Miss Joanna Tagart for the diagram.—I am, etc.,

R. E. B. TAGART.

Newmarket General Hospital,
Newmarket, Suffolk.

Venereal Disease and Young People

SIR,—Dr. Phyllis M. Dobbs (21 March, p. 766) concludes her letter by saying, "To me, the greatest immorality is to bring an unwanted child into the world." If she really believes this how can she seriously state in the same letter that she supports the practice of premarital sexual intercourse? I have no doubt that her advice will be taken by some people, and an unwanted child, or children, will be brought into the world following a sequence of thought and action prompted by the contents of her letter, which has unfortunately had wide publication in the national press.

Most young people, although they would be reluctant to admit as much, do take notice of what older people say, and, as well as being older, they will also assume that Dr. Dobbs is more mature in experience, judgment, and advice than they are. This is particularly true of children whose parents shirk the responsibility of guiding them in their formative years, and hence it is even more vital than ever that people in positions of responsibility should be extremely careful in the advice they offer.

I hold a weekly antenatal clinic, and the number of unmarried mothers attending is constantly increasing. I am able to form a fairly accurate opinion of the misery which results from a practice which Dr. Dobbs supports and which, apart from being contrary to Christian teaching, is good neither for the individual nor for the nation as a whole.

I need hardly remind Dr. Dobbs that the incidence of venereal diseases is also rising sharply, particularly amongst teenagers.—I am, etc.,

Plymouth, Devon. T. A. LLOYD-JAMES.

SIR,—I agree with all that Dr. A. G. S. Grimble states in his letter (4 April, p. 905) and that comparisons with pre-war figures of the incidence of venereal disease may be twisted to suit almost any argument. Moreover, the true incidence cannot be gauged without knowledge of the numbers treated outside the clinics, which may well be much more than forty years ago.

Undoubtedly to-day the standard of follow-up is often inadequate and takes no regard of the increasing difficulty in curing gonorrhoea, patients sometimes being discharged while still infectious—quite apart from defaulters. The failure in some quarters to regard non-gonococcal urethritis as a transmissible infection is a likely factor in the increasing incidence of this condition. I refer, of course, mainly to non-specialists outside the clinics.

While agreeing with all that has been said about chastity, such statements may seem platitudinous to the practising physician faced with patients of all grades of intelligence and from every social class who are reluctant to remain continent even if only until their infection is cured. Education of the young, particularly the female sex, is essential. In general, parents and schoolteachers are ignorant of this subject and require education by the medical profession. The profession itself has not always been well taught, and even now there are teaching hospitals without consultant physicians in venereology on their staff, though several have recently remedied this defect.

It appears that "the bomb" is a scapegoat for the present increased incidence of sexually transmitted diseases. The real cause is the increased prosperity of the nation, which in this context has had two results. Firstly, increased immigration has brought numerous unattached adult males into the country, thus, as in war, raising the incidence of these infections which these people almost invariably acquire after arrival. Secondly, the rising generation with more to spend than ever before have become a centre of attraction for those who want them to spend their cash and are subjected to a constant bombardment with the image of sex and its excitements. It is not surprising that some of them succumb, and it is the young girl who needs most protection.

If there had been widespread unemployment neither of these factors would have operated. No Government (whatever political parties may say) would have tolerated immigration under such conditions. Moreover, some towns affected with unemployment and consequent departure of immigrant labour showed a marked reduction in their V.D. figures during 1962.—I am, etc.,

West London Hospital,
London W.6. J. L. FLUKER.

Induction of Labour with Hypertonic Glucose

SIR,—In his letter to the *Journal* (14 March, p. 701) Dr. Donald W. Briggs reported a fatality which appeared to be due