Morphine in Acute Chest Infections

SIR,—Oedema of the glottis and asthma have in common a capacity of producing respiratory obstruction severe enough to call into play the accessory muscles of inspiration and expiration. Anaesthetists know that if oedema of the glottis is severe enough the patient will die if given a general anaesthetic, for the voluntary accessory muscles, on which for the time being life depends, are put out of action.

Chevalier Jackson points out that the relationship between an obstructed airway and central respiratory depression may be so delicately balanced that the administration of an average dose of morphine can make the difference between life and death. He warns the medical practitioner, faced with a patient in distress from oedema of the glottis, against giving him morphine before taking him to hospital for tracheotomy. Is it not probable that the death which follows the well-intentioned administration of morphine to a patient in an asthmatical attack can be explained on the same simple physical basis?—I am, etc.,

Oxford. R. R. MACINTOSH.

Dental Cavities in the Golden Hamster

SIR,—The report of Dr. J. D. King, "Dental Cavities in the Golden Hamster" (April 15, p. 876), has suggested a new concept regarding the primary site of those lesions of molar teeth of hamsters which heretofore have been considered comparable to human dental caries. Dr. King's results are especially interesting because they call attention to an aspect of the lesions not stressed by numerous investigators since 1942, principally in the United States (Dale, Keyes, Mitchell, Orland, Shafer, Sognnaes *et al.*).

Unfortunately the golden hamster has not been standardized for use in dental research as has the rat, so that this may account for some of the diverging results. For example, although Dr. King reports only 1.7%–6.4% of teeth affected after six months on a high carbohydrate diet, the usual comparable figure for teeth affected in our laboratory approaches 100%. There appears to be little basic difference in the diets as used by King and those used here; however, he did employ vegetable supplements twice weekly.

We were somewhat surprised by the statement that "in no instance could primary coronal cavitation be established." It is entirely possible that we are dealing with extreme strain variations in the animal, since in our laboratory the primary coronal cavity is by far the most common, initiating in the deep occlusal fossae. This type of lesion has been illustrated in published photographs by several of the above authors. In addition, many primary subgingival lesions such as Dr. King described are seen.

When a stock diet ("purina" rabbit pellets) is used, periodontal lesions associated with fibrous food and hair impactions beneath the gingivae are common. Yet no cavitation of the tooth develops, as Dr. King might suggest, associated with inflammatory conditions in the gingivae. The "calculus-like material" around the gingival area described by Dr. King is frequently observed in our animals associated with an erosive type of lesion which differs in appearance from the common coronal lesion. It is possible that this material, which, when moist, appears quite soft, is a type of caries-conducive plaque material. In time, chemical, biochemical, and bacteriological analyses may answer this question.

Probably one of the most interesting points that may be raised which shows some resemblance between human dental caries and hamster "caries" is the similarity in reaction to sodium fluoride–caries inhibition.—We are, etc.,

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The Training of the G.P.

SIR,—Without having seen the full report of the B.M.A. Committee on the training of the general practitioner I venture to make the following submissions.

(1) At the time when the taxpayer is very tired of the N.H.S. and its mounting cost, and at a time when the discussions about the Health Service have inevitably made our profession less popular than it was, it seems to me unrealistic to propose to increase by no small amount the nation's bill for its doctoring. (2) It is unrealistic because it assumes that there will be a recruitment for the eight years' course adequate for the needs of the country. (3) It is unrealistic to make the general practitioner into a pseudo-specialist in every branch of medicine, as all official pressure is aimed at turning out adequate specialists for all special subjects. (4) It is Utopian to plan the lives of G.P.s at a time when most of them are coping with panels that don't allow any leisure whatsoever. (5) It is unrealistic to count on trainees finding principals and principals finding trainees in equal and adequate numbers. (6) It is unrealistic to assume that there is nothing in the present curriculum that can be eliminated with advantage. I have pointed out elsewhere[1] a few of these subjects; there are many of them.

Finally, I hope the B.M.A. Committee will see fit to revise its findings and proposals in the spirit of realism rather than fantasy.—I am, etc.,

Harrow-on-the-Hill, Middlesex. H. CRICHTON-MILLER.

REFERENCE
[1] *Lancet*, 1945, **2**, 231.

SIR,—We endorse most warmly the masterly leading article in the *Observer* (May 28) on this report. With the experience of 25 years in general practice of one of us and of 15 years, terminated by the impossible conditions of rural practice for women under the N.H.S., of the other, there are, however, two points which we feel have not been sufficiently emphasized.

It appears to us more than doubtful whether a doctor, after three years' postgraduate training, will retain sufficient initiative to undertake the complete responsibility which is the duty of the family doctor. At a minimum age of 27 general practice at present offers no incentive, either financial or professional, after so long an apprenticeship. Could not the necessary postgraduate training be at the expense of a shorter undergraduate training?

The second point is that there is not at present—neither is there envisaged in the report—any hope for the middle-aged practitioner of improving his status, either professional or financial, in general practice. Until the good conscientious doctor can hope for betterment in prestige, leisure, and finance in his maturity the "flower of the profession" will not bloom, and most certainly will bear no fruit.—We are, etc.,

TREVOR HUGHES.
Ruthin, Denbighshire. ENID HUGHES.

The G.P. at the Crossroads

SIR,—Dr. A. Sanjana (May 20, p. 1201) says that a lot of work, demanding patients, trivial calls, etc., have always existed in practice in his area, and he wonders what kind of ideal practice Dr. E. Anthony (May 6, p. 1077) had before the inception of the N.H.S. I once acted as a locum in a mining area in South Wales and I was appalled at the conditions of practice there, with often 70 visits a day and over 100 at each of two surgeries a day. Care in diagnosis was impossible, snap judgments had to be made, and equipment was primitive, as there was no time to use any other.

I have a profound respect for Dr. Sanjana's physical endurance and integrity, but I would ask him, and you, Sir, whether he has brought forward any reason why these appalling conditions should apply everywhere. And, with all due respect, I am not surprised that he "wonders what kind of ideal practice Dr. Anthony had." I was only too glad to leave the locum