

and resulting hemiplegia should always raise the suspicion of progressive cerebral disease such as neoplasia until proved otherwise, if there has been a cerebrovascular accident there is an area of damaged brain capable of acting as an epileptogenic zone and of producing focal fits. These may be followed by post-epileptic paralysis, and it might thus appear that a further vascular accident has occurred. This is in fact the one type of "stroke" which could be prevented by the simple means of prescribing anticonvulsants.

Fine also draws attention to the possibility that some cases of post-hemiplegic pain—usually as intractable a condition as post-herpetic neuralgia—may be due to epileptic discharges, and, if so, preventable by anticonvulsants. This is a valuable idea, and shows how important it is by careful history-taking to define the characteristics of the pain—whether it is episodic and whether associated with any motor symptoms on the affected side. An electroencephalographic focus corresponding to the area affected would give additional support to the diagnosis, and treatment with anticonvulsants may be dramatically successful.

Great diagnostic caution is needed here, however. Cerebral tumours, whether primary or metastatic, can sometimes present as an acute hemiplegia and mimic a stroke in almost every way, but in an elderly patient who has previously had a stroke the possibility of post-hemiplegic motor or sensory epilepsy should be borne in mind. Though the condition may be uncommon, it can be amenable to simple treatment.

Referring the Patient

Increasing specialization in medicine has led to a problem that has sometimes put a strain on relations between general practitioner and specialist. It arises when a specialist finds that the patient has some condition, other than that for which he was originally referred, which would need the attentions of other specialists for investigation and perhaps treatment. The easiest and quickest course may seem to be for the first specialist directly to invite one or more of his hospital colleagues to take charge of the patient. In practice a doctor has sometimes sent his patient for a consultant opinion on, say, a chest condition, and in due course received with this opinion the information that the patient has been referred to a surgeon for a hernia, another surgeon for a cataract, and a dermatologist for eczema. This procedure is apt to bewilder both patient and family doctor, and there can be serious objections to it, not least from the point of view of the patient's welfare. With this in mind the Council of the B.M.A. has recently approved a recommendation of its Central Ethical Committee on the subject of acceptance of patients by specialists. The proposal will now go forward to the Representative Body at Bristol.

The existing ethical policy on acceptance of patients states:

"A practitioner in any form of specialist practice should not, except in circumstances stated below, accept a patient for examination and advice except on a reference from a general practitioner, or from another specialist, which should only be with the general practitioner's knowledge.

"The specialist should ensure that the true position is ascertained at the time an appointment is booked and should ask that an introductory letter be brought."

Exceptions included emergencies, consultations in venereology, and patients who were overseas visitors with no family doctor in Britain.

The sense of the new policy is that only so long as a specialist is himself concerned with the management of the patient may he obtain further opinions from his colleagues without first consulting the general practitioner. If the patient has a chest complaint the opinions of a radiologist or another chest specialist could be sought without reference back. Should the specialist decide that the patient has a condition which is outside his own field he must refer him back to his general practitioner. The specialist may not himself refer the patient to a colleague.

When the proposals were debated in Council (*Supplement*, 14 January, p. 9) some of the consultants present suggested that this procedure would waste time for both patient and doctor. The exceptions included in the proposals should prevent this. For example, in an emergency, or if the patient would be seriously inconvenienced, the code may be waived provided the specialist informs the general practitioner at the earliest opportunity of the action that he has taken.

If the Representative Body approves these proposals there will be no startling changes in relations between general practitioners and specialists. They have got on well together in the past by practising professional courtesy, and no one supposes that courtesy will diminish in the future. Nevertheless, support for the proposals could be a welcome sign that the profession as a whole recognizes the value to patients of a family doctor whose responsibility does not stop at the hospital gates.

Influenza

Influenza epidemics can be predicted with reasonable confidence only when a new subtype of the virus makes its appearance. In the absence of this event forecasts must be very tentative but may be attempted on the basis of the incidence of the disease in previous years, on the study of antigenic variation of the virus, and on the immune status of human populations as shown by serological methods. Experience in recent years indicates that when the disease is not pandemic it is often restricted to particular geographical areas.

Since 1957, when the A2 (Asian) subtype of influenza appeared, epidemics have been limited to certain countries or geographical areas during each particular outbreak. In Great Britain influenza has been prevalent during most winters, mainly in the form of scattered outbreaks but occasionally reaching epidemic proportions, as, for instance, in 1959 and 1961 (influenza A2) and in 1962 (influenza B). During the winter of 1965–6 outbreaks of influenza A2 and B were recorded in many areas in this country. No influenza has been reported here during the present winter, but since last November outbreaks of varying extent have been observed in Czechoslovakia, Bulgaria, Italy, and the U.S.S.R. Influenza A2 and B viruses associated with these outbreaks are closely related to strains prevalent in previous years. Both epidemiological and virological evidence suggest, therefore, that the incidence of influenza is unlikely to be high in Britain this winter. Consequently there seems to be no indication now for extensive use of influenza vaccines. But vaccination may be of value to protect patients at special risk, such as those with chronic debilitating diseases. Inactivated vaccines containing current influenza A2 and B antigenic variants are available and should confer some protection.