After Qualification

About half the *internes* will become *chefs de clinique*. Getting this appointment depends largely on whether a man has got on well with his *patron* or not. The appointment can be part- or full-time. The part-timer, who is appointed for one year with the possibility of renewal for another year, can set up in private practice at once in his own premises. The full-timer, whose appointment is initially for four years with possible renewal of three years, is allowed to see private patients at his hospital only two afternoons a week. The hospital duties of both are similar, and consist in teaching students both on the wards and in the lecture theatre. At the end of two years the full-timer may take an examination for the title of *maître assistant agrégé*. The examination is not anonymous, and hence a patron who is well disposed to his *chef de clinique* will do his utmost to get him through. After passing this examination a doctor may have to wait as an assistant for many years before having a department of his own.

Professorial chairs are filled by election, and professors from all over the country have the right to vote for the appointment of a colleague to a vacant chair. These appointments are full-time, but a professor is allowed to see private patients at the hospital two afternoons a week—as when he was *chef de clinique*—and he may also be called out in private consultation. Faculty deans are chosen by the professors, and hold their post for two years.

In the near future it is proposed to hold a national examination for admission to consultant rank for all French doctors under the age of 35, irrespective of their actual position in the academic hierarchy. This would give any doctor of merit whose work has reached the required standard a chance of becoming a consultant, and would minimize the effects of social standing, political prejudice, and personal favour or animosity, which up to now have had a profound influence on the career advancement—or otherwise—of every French doctor.

Registration

The *Conseil de l'Ordre* is the controlling body of all doctors in France, and to practise medicine after qualification the doctor

has to be placed on the register of the *conseil* in the county (province) where he intends to work. Each county has its *conseil* which is responsible to the national *Conseil*, and the members of this body are elected by the profession itself. The *Conseil* has many powers in a professional respect. It can take disciplinary action against a doctor, and suspend him from practice temporarily or even permanently. It considers itself responsible for the profession's ethical and moral standards, and is very conservative in outlook. For example, it is firmly opposed to contraception, and did all it could to delay the repeal of the Act of 1920 relating to this subject.

Specialization

More and more doctors are specializing and now have to take specialist diplomas. Studies for these can begin in the final year of the medical course and last for three or four years. For example, to obtain the diploma in obstetrics, which was created in 1955, a doctor has to do a three-year course. The first year consists of half-time clinical work and half-time anatomy and physiology with special reference to obstetrics and gynaecology. There is an examination at the end of this year, and usually only about a quarter of those who take it pass through to the second year. There is no further examination until the end of the third year, when there is a national written examination and an oral examination held locally.

Those who want the double diploma of obstetrics and gynaecology have to study a fourth year and take a further examination at the end of that time. This double diploma is now essential for registration as a specialist in obstetrics and gynaecology, although doctors already recognized as specialists and practising as such are not obliged to take the newly established diploma.

Thus at all stages of medical education and practice there are those who embarked on a particular phase before any changes were made, and those who started later and must conform to the new regulations. This has added a certain confusion to a situation which is already complex, and my British colleagues must forgive me if what I write today is not completely true tomorrow.

HOSPITAL TOPICS

Dressings in Hand Sepsis

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A number of patients attending hospital daily for dressings is a depressing sight for patients, nurses, and doctors alike. It is an accepted but I consider an unnecessary facet of the work of a casualty department, and, as Lowden (1953) has said, patients regard a visit to the casualty department as a reason for not going to work, even if the lesion is not incapacitating.

Since the exposure treatment of burns has been shown to be so successful, and in the belief that frequent dressings at a hospital department are more likely to introduce fresh infection rather than prevent it, an attempt has been made in the casualty department of the Royal Hospital, Sheffield, to reduce attendance at hospital to a minimum.

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Though this method has been used successfully in the department for all varieties of lacerations and abrasions, both clean and infected, patients suffering from septic hands were selected for the trial and a comparison was made between the traditional methods and a minimal dressing technique.

Present Study

Forty-six patients suffering from a septic condition of the hand treated between 14 November and 11 December 1966 were required to attend daily for a week unless healing had occurred earlier. Dry gauze dressings were applied by the nursing staff after the doctor had seen the patient.

Between 2 January and 29 January 1967, 60 patients suffering from septic hands were treated under the new regimen

as follows: the patient was seen on the first postoperative day; if the incision had been adequate, throbbing pain had gone, and there was little discharge. The lesion was dressed with dry gauze and it was suggested that he should return to work and renew the dry dressing daily himself before work and expose the wound to the air at night. Patients who worked in water or with food were treated the same way but did not return to work till healing had occurred.

The two groups were compared by occupation, age, diagnosis, and percentage who required incision and antibiotic treatment. Table I shows the diagnoses. It will be noted that the total exceeds the number of patients, as several had two lesions.

TABLE I.—Regimen by Diagnosis

	Regimen A	Regimen B	Total
Paronychia	16	25	41
Pulp space	12	12	24
Boils, etc.	8	8	16
Tendon sheath	0	2	2
Web space	1	2	3
Other septic lesions	11	13	24
Others	1	2	3
Total	49	64	113

Another interesting fact is that sepsis of the hand is more common in light than in heavy manual workers (Table II). This is probably because they tend to work with sharp instruments, and puncture wounds are a common cause of sepsis.

The criteria on which to judge the results of treatment are : (1) visible healing of wound, (2) tenderness no longer present, (3) return of full movement of the hand, and (4) the time the

TABLE II.—Regimen by Occupation

	Regimen A	Regimen B	Total
Sedentary ¹	2	3	5
Light manual	17	27	44
Heavy manual	13	12	25
Retired, housewife, etc.	13	14	27
Not known	1	4	5
Total	46	60	106

patient is off work. Another factor to be taken into consideration is the incidence of complications.

The results of the trial are shown in Table III, as assessed on the eighth day after treatment was begun.

TABLE III.—Percentage of Patients at 8 Days

	Movement	At Work	Tenderness	Healed	All 4 Factors
Regimen A ..	87	79	79	79	77
Regimen B ..	86	86	84	82	80

Complications occurred in 13% of those on regimen A, but in only 8% of those on regimen B.

Conclusions

The conclusions that can be drawn from this trial are that it is unnecessary to see patients daily for dressings if the condition is satisfactory on the day after incision, and that patients can safely apply their own dry dressings at home and can thus more easily return to work. Surprisingly patients approved of this method and have been weaned off the idea that bandages are necessary for healing.

Complications are not more common in those who apply their own dressings.

It is difficult to assess the financial advantages, but in the 60 patients on regimen B alone there was a total reduction of 300 hospital attendances in one week and a similar reduction of time spent by nurses in applying 300 dressings. There appears to have been no disadvantage in early return to work, and the percentage of complications was lower than when the previous method was used.

This paper is based on an M.D. thesis on hand sepsis. For the sake of clarity the bacteriological results, which are available, have been omitted and will be the subject of a further report.

I wish to thank Professor John Knowleden and Mr. Alan Handysides, of the Department of Preventive Medicine, for help with the statistics.

REFERENCE

Lowden, T. G. (1953). *Lancet*, 1, 118.

CONFERENCES AND MEETINGS

Sickle-cell Anaemia

[FROM A SPECIAL CORRESPONDENT]

An International Symposium on sickle-cell anaemia was held at the University of the West Indies, Kingston, Jamaica, from 8 to 10 January 1969.

The physicochemical properties of the haemoglobin molecule were described by Professor H. LEHMANN (Cambridge, England) with particular reference to the globin pocket. The latter was lined with hydrophobic radicals, into which the haem had to fit tightly. Water in the pocket caused oxidation to methaemoglobin. Most of the unstable globin mutations occurred in those residues which touched the haem, while oxygenation and deoxygenation laid bare different parts of the globin chains. Each animal and plant using haemoglobin appeared

to have a specially tailored haemoglobin, which was characterized by an individual oxygen dissociation curve as well as by other properties. By studying the latter it was possible to suggest the course of evolution.

Dr. W. C. MENTZER (Boston, U.S.A.), outlining the search for an agent which could modify or prevent sickling, described the use in three patients of weekly injections of 400–500 mg. of testosterone enanthate, which had been reported as inhibiting sickling induced by sodium metabisulphite in vitro. An increased work capacity and well-being, with cessation of crises, was observed. Though the red-cell survival time had remained the same the red-cell volume rose, probably owing to direct stimulation of the

bone-marrow. Unfortunately the side-effects of therapy severely limited the use of testosterone for routine therapy.

Natural History

Dr. R. GRAY (University of the West Indies) reviewed the work of the paediatric sickle-cell anaemia clinic. Since 1952 275 children with SS disease or S-thalassaemia had been seen at the University Hospital of the West Indies. Of the 122 children who had been studied in detail 63% had presented before the age of 2. At this age acute swelling of the hands and feet was practically diagnostic, while painful febrile crises were