It should be pointed out that the list-sizes represent half the totals for a two-man partnership, it being assumed that the visits were shared approximately equally. The locality is urban district. The area can be visualized diagrammatically as a semi-circle whose radius is 3 miles (5 km.), the surgery being at the centre-point of the circle. The numbers of visits included attendances at confinements at two general-practitioner maternity units—one 6½ miles (10 km.), and the other 8 miles (13 km.) away (in the same geographical direction from the surgery as the main practice area). Also included were visits from time to time to a chronic sick unit and an aged persons' home, and these were usually recorded as one "visit," though often several patients were seen. The graph also includes as "visits" (approximately once a week) general anaesthetic sessions at a dental surgery. The relatively high peaks in 1957 and 1959 are attributable to influenza epidemics (in October 1957 and February 1959). The general falling off since 1963 is due to the help of assistants, and the further fall since 1966 to the advent of a new principal.

It is anticipated, as it is by Dr. Marsh, that a further reduction in visiting patients' homes will be achieved by deliberate planning.—I am, etc.,

Chertsey,
Surrey.

D. G. DAVIDSON.

Real Reasons for Emigrating

SIR,—Why is the Australian general practitioner more content than his N.H.S. counterpart? He enjoys the respect of his patients to a greater extent than the English general practitioner. Unlike Dr. E. C. Gamble (3 February, p. 320) I do not relate this to payment through the nose. Dr. P. B. Forbes's comment (17 February, p. 450) that respect is indeed engendered by professional competence is apt. It is not suggested that the average Australian is more competent than the average Englishman; the crux of the matter is that over here one can exercise the skills for which one trained.

As a general practitioner over here I perform complicated obstetrical manoeuvres and do major gynaecological surgery. In England it would be virtually impossible to

combine general practice with a specialty. We assist most surgeons who operate on our patients, and are responsible for much of the postoperative care. Incidentally, a further reason for emigration is possibly the reluctance of consultants to pay their registrar for assistance with private patients even when off duty. The terms of service make no reference to this disquieting feature of some residents' commitments. The spontaneous promise of payment cannot be enforced, as I know to my cost. Minor surgical procedures are well within the ability of all doctors. In Australia the bulk of practitioners perform them. In England the majority were referred either to the casualty department or nearest surgical outpatient department. Best of all we have the privilege of responsibility for our own patients' care in hospital. The ham-handed operator is no more frequently encountered in the Antipodes than in the United Kingdom.

There is a direct relationship between the amount of work done and income. A financial incentive to work harder is no bar to good medicine; on the contrary. Many of our patients are expatriates from the United Kingdom. Much to my surprise they prefer the system over here. The family-doctor concept is still a real entity in Australia. Much of the sting of the doctor's bill is taken away by "hospital benefits"—in most cases 80% of the fee paid is returned to the patient. In cases of hardship an account is reduced or waived. Few complaints are heard about medical costs.

The average practitioner over here enjoys a better climate, a higher standard of living, a healthier doctor-patient relationship, better conditions under which to work, and most of all the work itself. In view of the above, I submit that continued medical emigration from the United Kingdom to Australia is ineluctable.—I am, etc.,

MATTHEW J. O'NEILL.

Mordialloc,
Victoria, Australia.

Recommendations of the Royal Commission

SIR,—It seems from your report (13 April, p. 109) that the Royal Commission on Medical Education¹ has not considered one factor which will upset all their calculations. The question is, to what extent is a medical training necessary to the handling of psychological problems? In practice about a third of the time and energy of a general practitioner is spent on such problems, varying greatly with the interest he shows. At what point should he refer them, and to whom? To what extent should drugs be used, and to what extent talk? Should we be training thousands of extra doctors or thousands of extra psychotherapists? It makes a lot of difference to the cost and to the results. I think myself that the bulk of psychological and social problems will be best delegated to therapists with the appropriate education and experience, working with and equal in status to doctors. The difficulty in planning such training is that we do not know how big the real demand is; what present needs are unrecognized; what new demands are likely to appear; and how people with a problem

choose which particular adviser to approach, or when they give it up as hopeless.—I am, etc.,

London N.3.

J. R. SCOTT.

REFERENCE

¹ *Royal Commission on Medical Education*, 1968, Cmd. 3569. H.M.S.O., London.

Verification of Qualifications

SIR,—In the light of the statement made by the General Medical Council calling on hospital authorities to verify qualifications (16 March, *Supplement*, p. 78), might I suggest that every practitioner in medicine and surgery should be granted a visa bearing his or her photograph, signature, qualifications with date of registration, and country of issue. This document should be endorsed by the Medical Registrar every three years.

This would bring the profession up to date, avoiding all the unpleasant sequelae associated with employment of bogus practitioners.—I am, etc.,

E. A. P. SUTHERLAND-RAWLINGS.

London W.2.

Points from Letters

Hypothermia in the Aged

Dr. J. A. J. MACLEOD (Lewisham Hospital, London S.E.13) writes: During December 1967 most of the emergency medical admissions to this hospital over the age of 65 had their rectal temperature measured on arrival in the casualty department, using a low-reading thermometer for two minutes. Of those whose temperature was properly recorded by a sister or a staff nurse 80 patients were over the age of 65, and of them 18 showed a rectal temperature of 96° F. (35.5° C.) or below.

Many old people living alone will admit to stoking up a dwindling fire on the day that they expect a visit from their conscientious relative, general practitioner, district nurse, or health visitor, thus creating a false impression of homely warmth. Would it not therefore be a worthwhile investment to provide all elderly people with a low-reading thermometer and a simple card of instruction for the measurement of oral temperature? The temperature could be recorded by any regular visitor. This would go a long way towards the detection of hypothermia and would be the first step in the prevention of the associated morbidity.

Medicine and Mass Media

Dr. M. GLASS (Cape Town, S. Africa) writes: Besides answering the critics of the heart transplant operation, Mr. I. G. Sacks's timely hard-hitting riposte (2 March, p. 577) "revivified the bloodless shadows of the past." Listening with my eyes I could hear the bitterness and disillusionment of Vesalius (1514-64)¹ as he ran the gauntlet of "the pestilential creatures who calumniate anyone they discover to know something unknown to them, admitting he is skilled in such things but that he is no physician, as if great diligence in some of the disciplines underlying medicine might detract from the knowledge of medicine. . . ." It is a pleasure to give my support to Mr. Sacks's spirited and loyal support of Professor Barnard's innovation.

REFERENCE

¹ O'Malley, C. D. *Andreas Vesalius of Brussels*, 1964, pp. 218-219. Berkeley and Los Angeles.