passed with negligible practical experience. There is no check relating to the operations undertaken by the examinee. There is no assessment of technical competence.

The bottle neck to the young surgeon's career after having achieved his Fellowship is at senior registrar level. Surely selection should be made before this belated time and assessment made each year of the trainee's progress. It is emphasized that it is difficult to acquire considerable amounts of theoretical work coincident with a busy and tiring post in the regional hospitals. Sound theoretical training is the sine qua non for a trainee before embarking on practical surgical training.

The worthwhile apprenticeships in practical surgery should be carried out in the busy regional hospitals under the training and surveillance of active, well experienced general surgeons. What matters is the establishment of a comprehensive and continuous training scheme in theory then practice. Ultra-specializations and research should logically follow and not be mixed up with the basic training, which could be over six years.

In conclusion there should be three years mostly theoretical work terminating with the Fellowship and the remainder of the time should be spent on practical training.—I am, etc.,

JOHN J. SHIPMAN

Hitchin, Herts

Surgical Ritual

SIR,—Unhappily your interesting and provocative leading article (2 September, p. 543) used an imprecise jargon: "it is highly desirable that patients have routine screening of chest and blood." Screening of the chest, literally fluoroscopic examination, is deplored in every radiological code of practice because of the unnecessarily high radiation dose to patient and radiologist. "Examination" would have been more desirable both for chest and blood.—I am, etc.,

JOHN F. LOUITT

M.R.C. Radiobiological Unit,
Harwell, Berks

Defence Society Subscriptions

SIR,—When the Medical Defence Union decided to increase the annual subscription so enormously, creating at the same time a new category of lower-rated members, it was inevitable that protests would be made. The first to reach your correspondence column has come—surprisingly—from a venereologist, Dr. J. D. J. Parker (19 August, p. 477). It is, however, not entirely clear whether he offers lower earnings, less liability to error, or less risk of litigation as a reason for him to pay less.

It would be possible to relate the level of subscription to earnings, and in some respects this would be fair though complicated to compute and collect. However, if there is to be a special "low risk" category it should be applied equitably and there are others besides administrators who should be eligible (not counting venereologists). For instance, there are the retired or semiretired general practitioners and others who do an occasional locum to help hard-pressed colleagues: they will probably opt out alto-

gether if they are required to pay the full amount. This will be a pity, since they form a valuable reserve of medical manpower in time of need. So too do the married women part-timers, many of whom do the sort of work which only marginally involves the management of patients—for example, F.P.A. clinics, blood transfusion sessions, school clinics, etc. It is extraordinary that the M.D.U. has not publicly defined "non-clinical" and "work not affecting the management of patients." Does, for example, examining an applicant for life insurance or disablement benefit constitute "managing" him?

Another matter not mentioned is the entrance fee. Is it still in force and still to be extracted anew from those who resume practice after an interval? Yet one more subject needs ventilating. I am told that those about to retire are advised to continue paying their subscriptions for several years after retirement in case a late claim arises. If such a claim should arise and relate to the time in which a practitioner was a fully paid-up member it would be monstrous if the M.D.U. were to refuse to defend him on the grounds that he had discontinued membership on retirement. Sir, who will defend us against our Defence Union?—I am, etc.,

LUCY TURNER

Cromer,
Norfolk

SIR,—The medical defence societies have recently been obliged to raise their annual subscription by a very considerable amount, and no sensible doctor will dispute that this increase is necessary in the circumstances. Nevertheless, as an older member of the profession in everyday contact with a cross-section of medical work I cannot fail to be struck by the frequent neglect to foresee, and so prevent, possible errors of record which may be a source of litigation later.

One hopes that the attention of the student in training is being brought to the importance of this side of his later professional work. If indeed it is the present result can be described only as singularly unimpressive when judged by the performance. The way to the mind may be through the pocket.—I am, etc.,

F. PYGOTT

Isleworth, Middlesex

The Artist's Eye

SIR,—The statement in your leading article, "The Artist's Eye," (19 August, p. 434) that red-green blindness affects every twelfth man was said to be incredible by Dr. Ann J. Gower (2 September, p. 586). With this in mind I am prompted to report my own experience. Earlier this year I conducted a survey of the colour-vision status, as defined by Ishihara plates, of all businessmen who attended a medical centre for routine medical examination over a five-week period. From

a total of 1,149 men 85 were found to have defective colour vision, an incidence of 7.4% (1:13).

Only 18 of the 85 affected men knew of their defect, suggesting that the remainder were either not tested previously or were misclassified as normal or that they developed the defect after being tested. The Table below shows the age distribution of colour-blind individuals compared to that of the normals. There is no significant difference between the distribution ($\chi^2=0.857$ on 5 D.F. $0.95>P>0.90$), indicating that the incidence of colour defect is independent of age over the range observed. It is possible that the main reason for these patients lack of awareness of their colour-blindness is the subjective nature of the disorder and the tests used to identify it, resulting in a large number of misclassifications.—I am, etc.,

J. D. WILLIAMSON

London N.9

"Colour Blind"

SIR,—Your leading article, *The Artist's Eye* (19 August, p. 434), falls into a common error of calling colour-vision-defective persons colour "blind." One in 12 of your male readers knows how incorrect this is. The majority of males with this defect do see colours but in muted shades, as the rest of us see colours of a winter's dusk, when we may make the same errors of confusion. May I make a plea that the term "colour blind" be abolished, save for those very few to whom it applies, and the proper term "colour-vision-defective" be substituted?—I am, etc.,

A. L. SMALLWOOD

Bristol 2

Neomycin's Mode of Action

SIR,—Your expert contributors have misinformed you about the mode of action of neomycin (10 June, p. 642). Since this is a polybasic compound, it is of course positively charged and causes precipitation of micellar lipids by interaction with negatively charged fatty acids and dihydroxy bile acids. As a result cholesterol is coprecipitated and its absorption impaired.¹—I am, etc.,

G. R. THOMPSON

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¹ Thompson, G. R., Barrowman, J., Gutierrez, L., and Dowling, R. H., *Journal of Clinical Investigation*, 1971, 50, 319.

Inducement to Prescribe

SIR,—Today I spoke to one of the representatives of a large, so-called "ethical" pharmaceutical company who offered to pay a chemist's bill in return for the prescribing of a specific, named product. I have never been bribed before (rather, no one has ever

	Age Distribution of Colour Defectives (Years)						Total
	20-29	30-39	40-49	50-59	60-69	70 + yrs	
Colour Defectives	4	20	28	26	7	0	85
Normals	49	224	347	332	108	4	1,064
All men	53	244	375	358	115	4	1,149