In each of these excellent articles comment is made about the Group Practice Loans Scheme and about its applications to the various reconstructions and alterations required in many practice premises. We built a new surgery in 1961, and, by way of lending support to the remarks of Dr. Fry and others, we would like to describe our experiences. These experiences concern the Group Practice Loans Scheme, and in addition we will venture to state what we have discovered about rates, income tax, etc.

On November 26, 1960, we commenced to apply for a Group Practice Loan. Although ours is a partnership of two, nevertheless the practice is rural as regards mileage, and we hoped for success. We applied at first for a loan towards a building with an estimated cost of £3,000, and later on this amount was increased to £4,000. Our application, then, was for a loan of £2,000.

One of us (K. H. P.) was interviewed by a Joint Committee on Group Practice Loans on behalf of the Executive Council, and the members of this Committee were extremely kind and encouraging about our plans. Their report was adopted by the Executive Council and we were very happy with the reception of our ideas. In the ensuing weeks and months considerable correspondence developed, and our plans, our estimates, and our partnership agreement were sent off on various occasions to various places. Eventually two doctors from the South of England came to see us, and they were most courteous, but they indicated that our application was not likely to succeed. The reason for this failure was, we would have thought, purely technical. It appeared to hinge upon whether or not our practice would be regarded, for the purposes of the loan, as rural. We were informed by letter on June 9, 1961, that our application had indeed failed, and we moved into our new building on the 30th of that month.

All the men, both lay and professional, that we have met over this matter, both in our local committee and from the Ministry, were most pleasant towards us. It seems, however, that it is the regulations which are cumbersome and difficult, and we found that to be failed at the very end by a technical point so fine as to have apparently escaped our local committee was somewhat disappointing.

For rating purposes, we found that our new purpose-built surgery is regarded as a commercial building. It is therefore rated at commercial rates, and these are higher than the average domestic rate. This seemed rather strange, especially since one of us (K. H. P.) had practised for over nine years from a rented surgery which, like many others, was part of an ordinary house; and certainly no special reassessment of rates had been made during that time. In a similar way, the electric supply to our new surgery is charged at a commercial tariff, which is also higher than that for domestic purposes.

The Inland Revenue, however, regard the building as professional, and no allowance for tax is given on the building or on any part of the building. It would seem that the surgery is in the same category as a shop, an office, or a house. On the other hand, had we been erecting a factory, or building a factory, and particularly one to do with exports, or had we been erecting a new farm building, then, we understand, income-tax relief would have been granted for the whole cost of the works. We are advised that this relief would be spread over 50 years in the case of a factory, and ten years in the case of a farm building.

We are writing about these details because we feel that they may perhaps lend a little weight to the pleas already most eloquently made by Dr. Fry and others.—We are, etc.,

Barnard Castle,
Co. Durham.

K. H. PICKWORTH.

J. WESTWOOD.

Surgery in General Practice

Sir,—In his answers to questions I felt that your emigrant doctor gave a fair picture of group practice in a large Australian country town (November 10, p. 1247). But I feel he has been quite unfair to the College of Surgeons, who, he says, "are trying to make a schism in the profession." Perhaps he would care to answer a few supplementary questions to clarify this assertion.

1. Does it seem proper that general practitioners without surgical diplomas or special training should be doing "gastrectomies, gall-bladders, hysterectomies, and the like"? As "the group had no higher qualifications among them," one is relieved to know that at least had the modesty not to "tackle abdomino-perineals." Tackle seems the right word.

2. How many of these major abdominal procedures did the group tackle in his six years with the firm? How many mishaps occurred with these operations due to inexperience? I mean accidents with the common bile duct, the ureter, or with haemorrhage or fistula, etc.? Did they ever find it necessary to call in a consultant from the College of Surgeons for any such?

3. Are the College of Surgeons justified in advocating that major surgery should be undertaken only by holders of surgical diplomas or by practitioners who have had special training and experience in surgery? It does seem to me proper that they should do so, first for the recognition of the status of surgical diplomas, for the skill and experience they have acquired in their training—although I don't agree that the College are "trying very hard to stop G.P.'s doing surgery."

4. Is this the way in which the College of Surgeons are causing a schism? By reserving the right to require the higher standards from those undertaking major surgical procedures? If so, I feel they are justified in their attitude and should not be held culpable for any schism so caused. Myself, I was not aware of any such, and hope it will never be.—I am, etc.,

Melbourne, Victoria,
Australia.

R. S. LAWSON.

Better General Practice

Sir,—Your annotation entitled "General Practitioners to the Fore" (October 27, p. 1111) has just come to my notice. Your quotations from Dr. J. H. Hunt were very depressing. His remarks carry the implication that the G.P. should be a diagnostician, preferably an astute one, and that he should perform supervision of his patients after the battle, so to speak is over, having had no part in that battle. Then he makes a plea for G.P. hospitals, and we are told the few that exist are going to be closed down.

The quotation from Dr. John Fry is superficially more pleasing, but with respect to Dr. Fry I must take issue with him. With all these facilities for radiological and pathological investigations it would be interesting to know how many blood slides, marrow smears, x rays, etc., he actually sees and how many he discusses with the appropriate consultant. I am not suggesting he should see every one, but we all remember in our days
in hospital when we would always see the instructive specimen or slide and have a few "pearls" dropped to us by the consultant and how stimulating it was.

I strongly suspect Dr. Fry just receives a printed slip with the answer on it. Does he do his incisions of abscess, reduction of Colles fracture, and other "minor" surgery or does he feel that these tasks require a consultant with 20 years' experience, or a pre-registration casualty officer?

I think most of us, deep in our hearts, know that when we enter general practice in the U.K. we are going to lose (through non-use) most of the skills we acquired in hospital with so much effort, that we are not going to keep up to date as much as we should (through lack of time and being "out of the swim"), and that we are not going to replace these skills with those that we do require, especially psychiatry.

The fact is that in general practice, for the vast majority of G.P.s he does do "signposting" and he resents it. He loses contact with his patients when he refers them and he gets minimum mental satisfaction and even less financial satisfaction. All this is in direct contrast with Canadian and American G.P.s, who have entry to the local hospital, can consult with specialists for advice but still retain their patients, and who get plenty of satisfaction in their work.

SIR,—The fact is that unless and until the G.P. is admitted to the hospital, and allowed beds and full facilities, he will, by the inexorable progress of medicine, be pushed further and further to the rear.—I am, etc.,

Harbel, Liberia. M. ROSEN.

West Africa.

SIR,—In your feature "Without Prejudice" (January 12, p. 116) the great "modern mystery" of the "work and place of the general practitioner" is referred to. I agree with your columnist that the initiative of the G.P. is nowadays frustrated because he is continually told that "he shouldn't do those things which they can do better in hospital."

In the same issue a Canadian G.P. (Dr. J. H. S. Geggie, p. 119) gives us a picture of how general practice is conducted in Canada, and this seems more like "real doctoring" to me. In Great Britain most of a G.P.'s time is taken up with trivialities, and the structure of the Health Service is such that a general practitioner has little time and no financial inducement to carry out proper investigation of his patients, who are therefore referred to hospital in large numbers.

Now it may well be that such an arrangement is for the public benefit, but it seems a pity to me that a properly qualified practitioner should be denied the opportunity to practise the skills he was trained in as a student. If the present trend continues, it may very well be decided by experts in medical education that a shortened course of training, with more emphasis on social science and less on scientific medicine, would in future suffice for those students who intend to spend their lives in general practice.

The other possibility is towards integration of the three great divisions of the Health Service. At present the G.P. is almost completely isolated from the hospital and public health services, which are in their turn isolated from each other. To achieve any sort of unity the G.P. must be given hospital beds and be paid for looking after hospital patients from a source other than the pennisious "Pool." Only by meeting his specialist colleagues in hospital can he hope to benefit from the stimulation and fellowship which only hospital doctors enjoy under present circumstances. Such meetings are vital to all doctors, and their lack produces a sense of professional isolation which only those who have experienced it can understand.

The moment of decision approaches. The G.P. can either rise to equality with his specialist colleagues or sink further still until his official as well as his actual position becomes that of "second-class medical citizen."

—I am, etc.,

Belfast 5.

J. D. H. MAHONY.

"Fucidin" and the Staphylococcus

SIR,—I read with interest the paper by Dr. G. T. Stewart and his colleagues (December 22, p. 1645). We have ourselves been working with "fucidin" on staphylococcal phage type 80 infections for the past nine months, and I must therefore take up one or two points raised by Dr. Stewart.

1. In discussing the findings of Barber and Waterworth they also found in vitro the inhibitory action of fucidin delaying the destruction of added penicillin. Dr. Stewart suggests that "this effect was observed . . . only within a narrow optimal ratio of the two drugs which would be difficult if not impossible to arrange in vivo. Synergy with penicillin G appears to be a theoretical rather than a practical possibility." This would appear to be a theoretical rather than a practical criticism, as they do not appear to have given penicillin with fucidin to any of their cases. We have now treated 21 cases with a mixture of fucidin 500 mg. and phenoxymethyl penicillin 300 mg. three times daily. We have found no evidence of drug resistance, nor has this combination yet failed to clear the staphylococcal infection.

2. Dr. Stewart further states "if the infecting staphylococcus is not immediately eradicated, drug-resistance of a high order can emerge rapidly." As stated above, we have not found this to be the case. In contrast we are at present treating a boy of 9 years with a severe osteomyelitis of his hip which produced a staphylococcus phage type 80 from blood culture. He has now been on treatment with the above-mentioned combination of fucidin and phenoxymethyl penicillin four times daily for five weeks. He is making continued clinical progress. His second-degree skin lesions (all showing staphylococcus phage type 80) have healed and his fever has settled. There is no evidence of relapse.

3. We would entirely agree that "it would seem prudent to restrict its use to cases in which the organism is resistant or the infection refractory to other drugs." However, the reasons for this approach are not the absence of precise knowledge of the metabolism, for it is becoming abundantly clear that side-effects are almost non-existent, but that this is such an excellent drug for the eradication of resistant staphylococci that its usefulness should be conserved. When used with phenoxymethyl penicillin in vitro resistance is slow to appear but eventually it must. For this reason it would appear to be rather foolish to accelerate the appearance of this resistance by using the drug topically, especially when there are plenty of other alternatives for topical use.

4. Whilst it is probably correct that a drug should be introduced to clinical use by bacteriological study, it must not be forgotten that there is often a wide difference between the findings in vitro and the practical