in its own right, although his immediate monetary reward may be greater. It is an unfortunate fact that in our society status is very often proportionate to income. As general practitioners we need not seek for status in society if we lack status within our own profession.—I am, etc.,

Kirby Muxloe, Leics. LOGAN MITCHELL.

SIR,—Three resounding cheers for the letters of Drs. A. P. Ross, C. J. Carr, and A. G. Graham (7 March, pp. 638–9).

I wish to add the following points:

(1) I have been qualified for eight years and have held registrar posts in general surgery, orthopaedics, and neurosurgery. My next two years will be spent in registrar posts in thoracic surgery, urology, and plastic surgery. At the end of that time, having been qualified for ten years, I hope to gain my first senior registrar post in general surgery. My salary will then reach the dizzy heights of £1,700 per annum. Forgive me if I fail to understand the envy of my general-practitioner colleagues.

It has been said that a senior registrar is to be considered as a man still in training. This is fair comment, but surely men who regularly and without supervision perform gastrectomies, frontal lobectomies, nephrectomies, etc., are not to be regarded in the same light as apprentice plumbers? Is their work not worthy of at least the same pay as a general practitioner?

(2) How did the fantastically absurd notion arise that general practitioners do 90% of the work? Is the work of a surgeon who saves a man's life by removing his extradural haematoma to be equated with the work of a general practitioner who prescribes a bottle of expectorant for his patient's cough? Is a general practitioner more physically and mentally tired after his day's work than a man who has been up all night dealing with a bad intestinal obstruction? How much of a general practitioner's work is an open-heart operation worth? Or an osteotomy of cervical spine?

(3) I gather that hospital doctors have no expenses. I know men who have spent hundreds of pounds in examination fees, rail fares, and hotel bills in order to acquire their much-coveted Fellowship. One friend took an expensive course in London while his family subsisted on full pay for the first month, half pay for the second month, and no pay at all for the last month.

Since qualifying I have spent so much on text-books that I dare not mention the total cost—it would break my wife's heart. The most recent acquisition to my library cost £21. If any general practitioner has recently bought a more expensive text-book I should be interested to hear about it.

In conclusion, I should like to say this. Remove the differential, and soon there will be no more consultants. Who would be fool enough to go through the grind of 12–15 years' training, with no security, constant moving from one rented house or flat to another (usually at exorbitant rents), with all the worry and strain of higher examinations, and low pay, eventually to earn the same pay as a general practitioner?—I am, etc.,

Newcastle upon Tyne 4. R. P. JERMAN.

Jung in the Dictionary

SIR, "Without Prejudice," 7 March (p. 626)—While the *Concise Oxford* omits "Jungian" it is perhaps a consolation to note that the *Shorter O.E.D.* mentions Jung's name. It appears, suitably enough, under "complex": "Jung's term for a group of ideas associated with a particular subject." This is the truth, if not the whole truth, about the Jungian term complex. But it is better than nothing!—I am, etc.,

London W.1. E. A. BENNET.

Collection of Evidence?

SIR,—The extraordinary volume of correspondence about the present state and future of general practice in the *British Medical Journal* during the past few months would appear to offer a valuable contribution towards the solution of the problems. I have been impressed by the quality of many of these letters, which show great thought, wide experience, and constructive suggestions.

Is there in action any mechanism for collecting and sifting this evidence of frustration and discontent for the use of our negotiators? Are the views of the "periphery" noticed, and could not further personal contact with some contributors who express particularly valuable ideas be a profitable, if somewhat unusual, practice for the Council or General Medical Services Committee?—I am, etc.,

Netley Abbey, Southampton. B. J. FOSTER.

Points from Letters

Treatment of Furunculosis

Dr. K. E. LANE (Bath, Somerset) writes: The recent correspondence on furunculosis leads me to ask your permission to indicate a treatment—first used, I believe, at the Bristol Royal Infirmary—which, so far as I know, never fails to control this condition. The patient takes a daily dath containing 1 oz. (28 ml.) of 10% hexachlorophene. This is continued for two weeks after all boils have disappeared—usually three to four weeks. Careful soaping of the perineum and any parts affected by boils is an obvious part of the instructions. The use of "soframycin" (framycetin) nasal spray is so simple, effective, and inexpensive as to be a routine prophylaxis even without preliminary swabbing.

Hexachlorophene is made up in a preparation called "sterzac" in the right strength. It is difficult to get this preparation anywhere other than the south-west of England, and this makes me wonder whether it is not comparatively unused in most places.

Absence of Asthma in Blind Children

Dr. DAVID C. MUNDY (Bromsgrove, Worcs) writes: For many years it has been my privilege to attend a school for blind children. What a happy crowd they are. There are about 150 at the school (all boarders) and, allowing for admissions and leavers, I must have examined and treated about 300 in all. I am writing to say that during the years I have not had to treat a case of asthma. I do not know what the occurrence rate of asthma is for the child population of the country, but I seem to see many more cases among the 5- to 15-year-olds in my practice. I shall be most interested and glad to have comment on my observation.

Finger Necrosis due to Mittens

Miss K. F. BURN, S.R.N., S.C.M. (Oxford), writes: Infants' nightdresses made with sleeves 5 in. (13 cm.) longer than usual, with a loose tie at the wrist, provide warmth and a deterrent to scratching, making the use of mittens unnecessary.

Quick Labour in Primipara

Dr. W. H. P. POAD (Nassau, Bahamas) writes: Yesterday I did a surgical induction on a 19-year-old white woman at term for pre-eclampsic toxaemia: the hind-waters were tapped at 5.25 p.m., when labour was not in progress. Labour started at 6 p.m., and the second stage at 7 p.m., to my astonishment and incredulity. In response to frantic pleas I went to see the patient and when I reached her the head was on the point of crowning. She delivered spontaneously at 7.30 p.m. a female child, weight 7 lb. 1 oz. (3.2 kg.). There was no perineal tear.

Having discussed this case with a number of my colleagues we were agreed that the lapse of time between the rupture of the hind-waters and onset of labour is the shortest of which we have heard. Furthermore a labour of 1½ hours is exceptionally short in a primipara.

Intrauterine Cry

Dr. KENNETH KAY (Nantwich, Cheshire) writes: I recently had a gravida-2 who developed symptoms of pre-eclampsia in her 38th week of pregnancy, having had a similar history with her first one. I induced labour by rupturing the hind-waters. This was easily performed and clear fluid was obtained. On withdrawing the Drew Smythe catheter the baby gave two distinct loud cries, so clear that the surprised mother thought that her baby was born.

The sister and myself were dumbfounded. I left my patient to go into labour and kept a careful watch on the foetal heart rate, which remained regular at 130. My fear of the baby aspirating fluid during the "intrauterine crying" was allayed when 24 hours later my patient had a normal delivery of a 7½-lb. (3.4-kg.) baby who cried lustily *after* birth.

Rheumatoid Otoarthritis?

Dr. C. B. COPE (Washington 25, D.C., U.S.A.) writes: The case for rheumatoid otoarthritis has been convincingly presented by Dr. W. S. C. Copeman (14 December, p. 1526). Before final acceptance pathological support of active involvement of these diarthrodial joints should be provided. But, more to the point, salicylate toxicity of therapeutic dosage must be excluded.

Migraine

Dr. D. K. RAY (Pengam, Monmouthshire) writes: Only two points can be raised about your articles on migraine (25 January, p. 219 and p. 225): first, could prophylactic use of ergot in the case of Drs. I. A. Guest and A. L. Woolf aggravate the ischaemic crisis (anterior cerebral syndrome)?

Secondly, I did not see any reference to nasociliary syndrome[1] in the article on periodic migrainous neuralgia by Drs. J. N. Walton and J. I. Balla. The treatment, of course, is different here—viz., nasal application of cocaine and adrenaline, not ergot.

REFERENCE

1 Charlin, C., *Ann. Oculist. (Paris)*, 1931, **168**, 86.

Correction.—We regret that the name of Dr. M. D. Summerling was inadvertently omitted from the end of the letter of Mr. John Atkins and Mr. Arnold Maran on Vertebro-basilar Ischaemia (7 March, p. 632).