Incidentally the cerebrospinal fluid in these fatal series was either clear or slightly hazy, death ensuing before the development of a frankly purulent meningitis; thus meningism was not a clinical feature.

I noted that the condition was not included in your excellent medical emergencies series, but, despite its rarity, it deserves a place in any future series.

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Hong Kong dog and the Tokyo trots

SIR,—In the *BMJ* (4 August, p 316) there is a query asking if the writer may take a small dose of sulphaguanidine when visiting Hong Kong. No doubt he has the Hong Kong dog in mind and I note that your correspondent thinks that he should not take the drug.

This puzzles me, as in my travels around the world I have become familiar with the Hong Kong dog, the gippy tummy, the Trinidad dog, the Tokyo trot, and several other strange animals that can ruin a week of one's holiday, and I have never failed to cure it in 12 hours or less with three or four four-hourly doses of Guaninycin (sulphaguanidine, dihydrostreptomycin sulphate, and kaolin) or Streptotriad (sulphadiazine, sulphadimidine, sulphathiazole, and streptomycin sulphate). Not only in civilised areas but also on archaeological digs at some of the wildest camp sites in Egypt, Sudan, and the Middle East, it works equally well in people who, otherwise healthy, have been stricken with the dog, which can come like a bolt from the blue and lay a man low in a very short time. The victims of the dog have always regarded it, as I have done, as a gift from the gods, so I wonder greatly why you do not recommend such marvellous, wonderful, and almost instant health-giving remedies as Guaninycin and Streptotriad for this vicious animal.

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Primary anaerobic peritonitis

SIR,—In his article on anaerobic peritonitis (13 October, p 903) Mr Philip Matthews comments that his reported case appears to be the first such case of primary origin recorded in the literature. We should like to report a recent fatal case from the Western Infirmary, Glasgow, which shows some notable similarities.

A 16-year-old girl with no previous medical problems and no recent illness developed epigastric pain, vomiting, and diarrhoea. The illness was associated with a fever and was initially thought to be of viral origin. However, the symptoms progressed and by the third day she was severely ill and showed signs of peritonitis. She was transferred from an island off the west coast of Scotland to the Western Infirmary, Glasgow, where she was found to be gravely ill, being semi-comatose with a blood pressure of 80/100 mm Hg, pulse 160 beats/min, and a temperature of 39.5°C. Her abdomen was slightly distended, resonant, and silent, with widespread peritonism, notably in the right iliac fossa. Some mottling of the lower legs was noted. X-rays showed free gas under the right diaphragm. Full blood count showed a profound neutropenia with a total white cell count of $2.5 \times 10^9/l$ in spite of severe dehydration. The complement of white cells was composed mostly of premyelocytes.

Despite intensive resuscitative measures to

improve her general condition prior to any surgery, including rapid fluid replacement and the administration of gentamicin and metronidazole, her blood pressure remained low and unstable. Four hours after her admission and despite her grave condition it was decided to operate as a definitive step to remove the source of the presumed septicaemia. At laparotomy, the presence of free air was confirmed and a large quantity of straw-coloured intraperitoneal fluid was present. The lower ileum, caecum, and ascending colon were grossly oedematous and discoloured, although not frankly gangrenous. All retroperitoneal tissues in the right flank were swollen and crepitant. The liver was enlarged and also contained gas. There was a general peritonitis, although the appendix and pelvic organs were otherwise quite normal. Unfortunately, but not unexpectedly, the patient had a cardiac arrest during surgery and could not be revived.

At the necropsy the next day the body showed advanced decomposition. The operative findings were confirmed and showed the absence of any pathology either within the abdomen or in other tissues to account for the origin of the infection. In particular there was no evidence of disease of pelvic organs. The bacteriologist reported a heavy pure growth of *Clostridium oedematiens* from the intraperitoneal fluid.

The above case is similar in several respects to Mr Matthews's reported case. Notably, both patients were 16 years old and were otherwise healthy with no precipitating factors. The organisms in the two cases differed. The clostridium found in the present case probably accounts for the irreversible shock, profound neutropenia, and ultimate death. The severity of this terminal infection was out of keeping with the three-day history and may indicate that the original infection was more mixed—in Mr Matthews's case infection with a fusobacterium was accompanied by a leucocytosis of $27.6 \times 10^9/l$ despite a history of only 24 hours.

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Treatment of hyperhidrosis

SIR,—We read with interest the paper by Dr I A MacFarlane and others (13 October, p 901) confirming previous reports of the effectiveness of aluminium chloride hexahydrate in absolute alcohol for the treatment of hyperhidrosis.

We have treated three patients with this condition for up to 18 months with 20% aluminium chloride hexahydrate in industrial methylated spirit with excellent results. The cost of absolute alcohol is currently £4.47 per 100 ml including excise duty. The cost of industrial methylated spirit is 7.5p per 100 ml.

If, as seems likely, this preparation is to become the first-line therapy for hyperhidrosis, we think that it should be prescribed in industrial methylated spirit, as we can think of no justification for using the vastly more expensive absolute alcohol.

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Penis captivus

SIR,—The fascinating review by Dr F Kräuph Taylor (20 October, p 977) on the emotive subject of penis captivus deserves to be

followed by a spate of anecdotal correspondence. Perhaps I might make a small contribution.

While serving with the RAMC in the Gold Coast in 1941 I became aware of an African publication known as the *Ashanti Pioneer*. I cannot recall whether it was published daily or weekly but its content had a Rabelaisian flavour that endeared it to some of the European expatriots. I was shown a paragraph cut from the paper and carefully preserved by its delighted owner. It described a case of penis captivus with a wealth of detail, including the name of the remote village where the affair took place and the difficulty in hoisting the embarrassed couple on to a lorry for 30 miles of bumpy transport to the nearest government medical officer. His use of chloroform for the woman resolved the situation.

It is, of course, possible that the episode was a journalistic fabrication but the naming of the village and of the doctor concerned made me feel at the time that the event had indeed taken place. It is probable that others of your readers who have worked overseas will be able to add other cases to the few records collected by Dr Taylor.

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Medicine in the USSR

SIR,—As a doctor who qualified in the USSR, I feel obliged to challenge one of Dr Michael Ryan's conclusions (20 October, p 979). On the basis of one case of poor prescribing and another case of a hernia being missed he arrives at the alarming conclusion that "By British standards, these [Soviet medical education and practice] appear to leave a lot to be desired. . . ." Surely, as one who claims knowledge of the scientific method, Dr Ryan should know better. These cases do reflect badly on Soviet medicine but are insufficient evidence to justify the conclusion reached. Isolated cases of laziness, lack of attention to detail, or even frank incompetence on the part of doctors can be found everywhere, including Britain. I have recently been associated with a case of missed femoral hernia and yet I have not concluded that British doctors cannot diagnose hernias.

Statistics were introduced into medicine to curtail prejudice and encourage logical conclusions. If Dr Ryan seriously thinks that Soviet medical education and practice are inferior, he must come up with scientific evidence to prove it. I found his article very prejudiced.

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Lack of flexibility in vocational training?

SIR,—I write to say how profoundly I agree with Dr D P Brown's letter (27 October, p 1078). The best general practitioners are born, not made. By a combination of instinct and insight they know already much of what many vocational training courses seek to spell out so laboriously today. One encountered the same instinctive ability in good grammar school masters between the wars, who did not need three years' instruction at a teachers' training college to become good teachers.

For those of us in the second rank of GPs, who are, of course, the majority, vocational training can undoubtedly be of great importance in moulding attitudes and in developing clinical skills. Unfortunately it can be manipulated to serve undesirable objectives. That so many of these courses are in the hands of zealots more concerned with the power game than with the careful development of their own practices is a matter for deep concern. The danger is that some trainees will become conditioned to an attitude that places a higher value on group discussions and on committee decisions, on conformity to a norm established on high, than on personal commitment to the care of one's patients.

Indeed, perhaps the biggest problem facing us today is that young doctors tend to be shielded for too long from direct and continuing acceptance of clinical responsibility for their own patients in their own practice. This commitment must be the ultimate goal of all training, and to defer its realisation unduly is a fundamental mistake.

Speed limits, and tests for learner drivers, have to be set with the objective of making the worst drivers as safe as possible; one accepts that. But the analogy should not be applied strictly to training for general practice, or we shall destroy that individuality and sense of personal commitment which is at the core of our work.

The imposition of a rigid three-year package, culminating in the membership examination as the sole portal of entry to general practice, in a service under the control of a monopoly employer would be a disaster for our patients. Dr Brown's letter underlines the real threat that just such a process is now taking place.

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The middle grade

SIR,—Since surgeons and physicians have to have assistants but train more than one successor during their life time, the career structure must by necessity take the form of a pyramid. I have never understood how this basic fact can be ignored. It seems to be accepted by other professions. Not every major becomes a colonel or every teacher a headmaster. But in medicine today everyone who has put a foot on to the bottom rung of the ladder demands a guarantee of promotion to the top.

It has not always been so. When I worked for the London County Council before the war, I met competent men who preferred a 9-5 (or 10-4) job to the atmosphere of Harley Street and the medical school. I remember a physician who because of a mitral stenosis wanted a quiet life, and a surgeon who did a very adequate cholecystectomy or hernia repair but whose passion for bridge filled up all the spare time which he might have spent on reading or on attending meetings. It was accepted that they would not set the Thames on fire and that they had exchanged a fairly limited salary for a more peaceful existence. I believe also that there was no shortage of applicants for such a grade. I knew several SHMOs who were perfectly happy with their lot. But nothing was heard of them, since it was not they who organised protest meetings or wrote letters to the press. The grade may

well attract a man who has difficulties with examinations or likes to get home to his children when he has finished his work.

A few months ago I listened to a BBC programme called "The Leader of the Orchestra." The duties of this man were described (rehearsals) and his position (spokesman for the orchestra and sometimes mediator between it and the conductor), and then finally the interviewer felt obliged to ask the awkward question: "How did they feel about not having reached the top?" The replies were much in line with my thinking. They were given by people to whom a quiet life of an orderly foundation had greater attraction than the hectic glamour of the star performer with its richer rewards but its nervous strain.

The value of such appointments to the hospital service has been amply described by Professor Norman Browse (15 September, p 682) and I need add nothing to that. I will be told that an assistant grade could easily be abused. But any relationship can be abused, and I am not particularly impressed by this charge because I have heard junior staff complain alternately that the chief "never lets them do anything" or that he never turns up and that they "do all the work." What I would admit is that it is the detractors who get the publicity nowadays, whether their subject is marriage, parents and children, or medical career structure. It was the detractors' sneer about cut-price consultants which led to the end of the SHMO grade, a grade of the greatest value to the hospital service and one which can give immense satisfaction for that very reason.

E G HERZOG

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Medically qualified preclinical academics

SIR,—A report on medical academic staff (14 July, p 146) mentions that the Vice-Chancellors and Principals Committee is examining the possibility of medically qualified preclinical staff being offered clinical appointments. I would like to point out that a concurrent clinical attachment should not be the prerequisite for a better income. Many such academics are primarily inclined towards basic research, and indeed contribute significantly to medical knowledge. The research output of these valuable workers will be hampered by this new responsibility, which would be regarded as a form of "moonlighting."

The award of an equitable remuneration should instead be based upon the simple and obvious fact that medically qualified preclinical academics play a vital role in the professional training of medical students.¹ In view of the rapid scientific advances and increased curriculum loads nowadays, only such academics have the competence to rationalise, select, integrate, and teach effectively those basic principles which are relevant to professional requirements. We have only to recall our own preclinical experiences to realise that much of what was essential was invariably taught by medically qualified staff; their professionally orientated guidance not only facilitated learning and generated interest but also provided a sound and lasting foundation for the clinical subjects.

Commonwealth universities also have difficulty in recruiting medically qualified preclinical teachers because of poor salaries in

comparison with clinical scales. The well-known unsatisfactory effects of this deficiency need no elaboration. Only one Commonwealth university in the Far East, to my knowledge, laudably attempts to minimise the salary disparity by awarding a "medical allowance" to attract and retain medically qualified preclinical academics; but no clinical attachment is necessary.

Administrators often voice concern over the serious shortage of medically qualified preclinical teachers and yet, pathetically, lack the foresight to tackle the real root of the problem. Policies appear to be influenced by non-medically qualified key administrators who presumptuously decide the preclinical needs of the medical profession. An example of this is the grossly unsound opinion of the Department of Education and Science that a medical qualification is not needed.

We must unite in pressing for a satisfactory solution and make it clear that all decisions on our professional requirements are entirely our responsibility. I am sure that all medically qualified preclinical teachers in Commonwealth universities will be following with great interest the achievements of the Medical Academic Staff Committee.

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¹ *British Medical Journal*, 1979, 2, 146.

² Lewin, W. *Journal of the World Medical Association*, 1978, 25, 76.

Consensus management

SIR,—Professor G P McNicol's comment on consensus management (6 October, p 844) prompts me to invite him to come to Dundee. We think that he will find an executive group which is neither mediocre, indecisive, lacking in imagination and drive, or prone to shilly-shallying and procrastination.

We could not identify a prima donna in our mixed sex group, but what we do have is a sense of humour which enables us to take such generalisations in our stride.

G G SAVAGE

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Medical examination for elderly drivers

SIR,—I would like to be enlightened about the present situation between the BMA and the motor insurance companies over this matter.

Some years ago I wrote to the BMA about this and received the reply that negotiations were difficult but in hand. Since then I notice an increasing number of the elderly, hesitantly proffering their report forms which all contain the sentence "any fee charged must be payable by the policy holder." Some companies, with crocodile tears, have inserted the word "unfortunately." Surely, this unsatisfactory, embarrassing, and sloppy state of affairs has gone on long enough.

I feel strongly that this examination should be paid for by the insurance company that requests the certificate, and I do not understand why this is not the norm. After all, these insurance companies have all had hundreds, if not thousands, of pounds in premiums from their senior citizen clients in