practise in any field (except, of course, where it is politically or financially more expedient to overlook such necessities). We should do well to remember that most medical work now is restricted and repetitive and plan our student choice and curriculum on that. Otherwise we too may soon not attract high or low fliers. To suggest that we try to seek mediocrities is to imply that we wish to debase ourselves and what we offer. Normally only those who have failed in their trade do that. Professor Shuster has not done so. Why does he suggest it for his successors?

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Beta-blockade, myopathy, and thyrotoxicosis

SIR,—I think that the observation of Dr M Uusitupa and colleagues concerning the development of thyrotoxic myopathy (19 January, p 183) in patients on β -adrenergic receptor blockade is an important one, because this therapy is likely to mask many of the other manifestations of thyroid overactivity.

They quote a paper of mine concerning the frequency of electromyographic abnormalities in thyrotoxic patients (an incidence in fact of 92.6%),¹ but go on to say that "clinically evident myopathy is infrequent." In the same paper I presented evidence from five different authors' series (including my own) to show that clinically apparent muscle weakness is present in from 55% to 81.5% of thyrotoxic patients if carefully looked for. The diagnosis of thyrotoxicosis should always be considered in a patient with proximal myopathy.

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¹ Ramsay ID. *Lancet* 1966;ii:931-5.

Massive bleeding from large bowel

SIR,—Your leading article (16 February, p 425) is entitled "Massive bleeding from large bowel." It is surprising to be advised that, presumably on the basis of one team's flow chart, a series of investigations should be undertaken, culminating in mesenteric angiography; and that, should this be negative, further exclusions should be made before invoking laparotomy "as a last resort if haemorrhage still continues." This approach may be diagnostically satisfying, but it ignores the grave risks inherent in delaying surgery when massive bleeding is still taking place. Concomitant anaesthesia for what has by then become inevitable surgery is not without intraoperative risk, since the patient is likely to be in poor condition at induction and in need of continuous resuscitation. These circumstances cannot augur well for the postoperative course.

It could be argued that use of the term "massive" in the title might be misleading, when elsewhere in the editorial "acute" (defined as "requiring a transfusion of five or more units of blood") and "major" (undefined) are used synonymously. The management recommended may be valid when bleeding is persistent but not immediately life threatening. Otherwise it would be preferable, we think, to intervene before the hazards of surgery and high-risk anaesthesia become too great.

We appreciate the difficulty in localising the site of a large bowel haemorrhage, but the investigations advocated do not always produce a solution. Although only a minority of patients need operation, it is important to decide on early selection and surgery in this group.

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Rehabilitation

SIR,—Mr P R J Vickers's letter (12 January, p 111) highlights yet another medical dilemma. All agree that rehabilitation is the responsibility of the clinician caring for the patient in the acute phase of the disease causing the disability, and most clinicians agree with Mr Vickers's restatement of Sir George Pickering's criticism, made in 1949,¹ of the failure to apply the experimental method to the practised techniques of physiotherapy and occupational therapy, many of which are of dubious value.

Apart from the failure of medical teachers, with few exceptions, to recognise the need for undergraduate medical instruction in rehabilitation, there is also, alas, the lack of interest in the subject by both hospital medical staff and the primary care physicians. Rehabilitation medicine as a specialty attracts few recruits in England and, indeed, it seems unlikely to do so if it is totally divorced from an interest in acute illness. Nevertheless, the rehabilitation services at district level require to be developed and organised to meet medical needs. These can only be determined by medical decisions and advice.

The rheumatologist today undertakes not only the consultant responsibilities in connection with inflammatory joint disease but the medical management of sports and acute soft tissue injuries, spinal disorders which do not involve surgery, and other medical disorders of the locomotor system. In accepting responsibility for the rehabilitation of his patients he must have sound knowledge of rehabilitation medicine and, in many instances, he is the consultant charged with the medical responsibility for the development and organisation of the rehabilitation service for his consultant and GP colleagues in the district general hospital. The recent circular on management in the remedial professions is in keeping with this view.

The link between rheumatology and rehabilitation is historical, but it is also practical. At this time severance of the link would in many areas undoubtedly lead to a deterioration in the service.

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¹ Pickering GW. *Proc R Soc Med* 1949;42:229-34.

Illegal immigration and medical confidentiality

SIR,—Dr Anthony Hall's (23 February, p 569) rigorous view of a doctor's policing duties will not, I hope, commend itself to the profession. Medical confidentiality does require some conflict with the law and some detachment from the social objectives of the State.

May I make a plea for a sense of proportion?

The touchstone of the doctor-patient relationship is that of friendship. Some offences, of which Dr Hall mentions heroin pushing, are so serious that they justify a doctor in breaking confidentiality. Illegal immigration surely does not come into this category. In this respect it is regrettable that the form FPI requires that the patient's place of birth be recorded. While the intention of assisting the tracing of records is no doubt innocent, it is wide open to abuse by the zealots of surveillance.

It is to be hoped that doctors will continue to use their judgment. Some offences are so heinous that confidentiality in their presence constitutes a betrayal. Other offences, and this is especially the case in a world ravaged by ideological fury, offend policy rather than truth. For these we should follow the advice of the smugglers' song and "watch the wall, my darling, while the gentlemen go by."

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Inner city general practice

SIR,—I would like to support Dr Ronald Griffiths's plea (23 February, p 570) for more opportunities for young doctors coming from the vocational training courses in London to settle in the inner city area.

In the St Thomas's District we have been fortunate in that four or five of our trainees have been absorbed into existing partnerships, but the chances of their obtaining a single-handed vacancy appear to be negligible. Many of these young doctors are highly trained and highly motivated and could almost certainly make an important impact on primary health care in these areas. While accepting that there may be special problems for a young doctor without a great deal of experience in general practice in undertaking a single-handed practice, it does not follow that two or more years' experience in general practice ensures that a candidate is better able to deal with these problems. The crucial question concerns the quality of the previous experience, and if indeed that experience has been bad his patients would probably be better off with a new, vocationally trained doctor.

I hope that the Medical Practices Committee will give this matter very serious consideration; otherwise we will continue to lose our vocational trainees into partnerships in other parts of the country and will not have the benefits of their fresh ideas in developing general practice in London.

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SIR,—Dr G E Crawford in his excellent article "A lifeboat for inner cities" (16 February, p 500) rightly points out that one of the oars should be manned by the general practice presence in the medical school. Unfortunately the lip service that has been paid to the priority for primary care in medical education has not been matched by resources.

General practice departments are understaffed and underfunded. Not one penny of the several millions of National Health Service funds paid to area health authorities to support their teaching commitment finds its way into primary care. It is only in general practice that there has been such a total