postgraduate education, and most of the remainder will be doctors who are well read, have attended refresher courses, are members of medical societies, have hospital posts, live near postgraduate centres, and are engaged in active continuing education.

Open-circuit medical television has probably been overtaken by the rapid expansion of other forms of postgraduate education. In the academic year 1969-70 10,000 hours were spent by 1,021 general practitioners in the Newcastle region in intensive or extended postgraduate courses. The regular lunch-time meetings held in 12 postgraduate centres and a variety of case conferences and clinical attachments probably double this total. The maximum estimate of medical televiewing is 2,000 doctor-hours in the region, and in reality may be much less. Isolated from the main stream of activity in postgraduate centres medical television is handicapped by production delays, which inhibit the presentation of current topics, by frequent failure to exploit the technical possibilities of the medium, and particularly by an inability to involve the viewer.

If medical television is to continue the function of the programmes might be more clearly defined and specifically aimed at doctors in postgraduate centres. A national or regional curriculum of short, provocative presentations could be interspersed with regular current-affairs programmes requiring less elaborate production techniques and transmit-

ted during the lunch-hour periods as "discussion openers."

Perhaps of greater value than the education of doctors is television's potential for informing the public. While our study suggests that lay audiences are small, previous estimates had been higher³. If, as Robert MacNeil⁴ claims, "Television reaches, persuades and informs more extensively and homogeneously than ever before," programmes dealing with smoking, obesity, exercise, personal relationships, contraception, child development, accidents, the use of medical services, and other topics involving doctors, social workers, psychologists, educationalists, therapists, and patients would be a much more effective use of the facilities available.

Medicine is increasingly dependent on its partnership with the public.

Our survey seems to suggest that enough is being done to educate the doctor; the emphasis should now be on the patient.

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Hospital Topics

Early Walking of Geriatric Amputees

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Summary

After amputation geriatric patients have been enabled to get up and walk with the help of a prosthesis, an "early walking aid." The physiotherapist measures the patient, fits the early walking aid, and instructs him in walking. The prosthesis is simple to make, easy to apply, and allows early walking with the use of a walking frame or sticks. Thus the geriatric amputee can walk as soon after operation as his general condition allows and the surgeon wishes.

Introduction

Since certain patients for various reasons were unable to attend the nearest limb-fitting centre some 40 miles (64 km) away, they were referred to the geriatric-orthopaedic unit at St. Helen's Hospital, Hastings. The plight of these patients indicated that some simple appliance should be made to allow them at least independence in the ward. The first appliance

made was no more than a sawn-off crutch with a polyethylene socket made from a plaster cast of the thigh (Fig. 1). It was less sophisticated than a wooden leg made by a sailor after Trafalgar, but its success exceeded all expectations. Thereafter early walking aids were in great demand for all patients undergoing amputation.

Patients and Method

Since 1962 123 amputations have been carried out by the general surgical staff. It is not my purpose to describe here in detail the reasons for, or technique of, operation in these geriatric patients. The overall production of the early walking aid was my only concern. This was a deliberate policy to enable the physiotherapist to take her proper place in this programme. All decisions as to when the patient should walk rested with the surgeon and the physiotherapist.

Before operation the necessary measurements were taken, so that, if possible, the patient's new "leg" was at the bedside when he awoke from the anaesthetic. There was no advantage in getting the patients up immediately after operation—one or two weeks later, according to fitness and progress, was soon enough—but during that time exercising the stump with the early walking aid attached produced a better stump than simple exercises or bandaging. Thereafter amputees attended the limb-fitting centre as usual.

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FIG. 1—One of the first early walking aids.

MEASUREMENTS

Measurements are taken before amputation where possible. A cast of the knee and thigh is taken and the anterior midline marked on the cast, which is then split down the side, removed, and reconstituted. When the amputation has been carried out as an emergency, the cast is taken as soon as possible after amputation, a small dressing being placed over the wound. Measurements are also taken of the patient's waist, the waist to the great trochanter, the great trochanter to the knee joint, and the knee joint to the floor; the medial and lateral leg length and the size of the shoe are noted on a label, which is attached to the cast with details of the patient and the side of amputation.

CONSTRUCTION OF THE PROSTHESIS

The cast and the measurements are sent to the orthopaedic workshop, where the orthopaedic technician makes a simple positive of the cast; on this, in an ordinary oven (such as is used for Plastazote), a polyethylene socket is made. This is then attached to two side pieces, as made for calipers, with the knee joint positioned at the correct height (Fig. 2) according to the patient's measurements. The lower end of the two side irons are fixed, when possible, to a reclaimed calf piece of an artificial leg, and a foot piece of the right size is attached; otherwise a simple rocker is used, as for a pylon. The socket is usually lined with plastic foam which is stuck on with glue. A waist belt is fixed to the top of the socket with a swivel—these are also reclaimed parts. The leg can then be fitted by the physiotherapist.

Results

Of the 123 patients 80 used the early walking aid. The average age at amputation was 74 years, and the diagnoses included arteriosclerosis (95), diabetes (21), certain other conditions (6), and one unknown. The survival rate (see Table) emphasizes the urgency of getting a patient mobile after

FIG. 2—An early walking aid shows the simple method of construction.

Survival after Amputation

	No. of Patients
Died within two months (all in hospital)	31
Died after two months, but before one year	12
Total dying within one year	43
Survived one year	61%
Survived two years (excluding 1969)	47%

amputation because of the high early mortality in the ensuing months. Without early walking many patients would be denied a period of independence, even if only in hospital.

The patient's chance of leaving hospital after an amputation was two out of three (see Table), and his chance of surviving two years after amputation was about 50%. It is, therefore, extremely important that the last months of those who have had amputations and who are not going to survive should not be spent confined to a hospital bed through their inability to walk.

Discussion

The mysticism that has grown up around the technique of fitting artificial legs is such that any other form of appliance given to an amputee is looked at askance. There is, however, no need for such an attitude, particularly if it denies the chance of walking to a geriatric amputee who has probably only a short while to live.

The most important indication for early walking after amputation in the elderly is to achieve early independence. The tranquillity of mind that this regimen produces is enormous, particularly before operation, because often a prospective amputee is able to see another patient who is up and walking with an early walking aid. This factor of raising the morale of a patient cannot be emphasized too much. Secondly, the mere fact of having the artificial leg available after the operation, even though the patient does not walk on it at once, convinces them that they will walk, and they are therefore mentally prepared for their discharge from hospital.

Thirdly, the use of the appliance exercises the stump, and this is the best rehabilitation. Some patients are able to go home on the walking aid, but those who do not are no longer confined to their bed in the ward. It is quite common for patients with arterial disease necessitating an amputation to become confused or in other ways unable to face up to the challenge of their independence outside hospital. This tendency is probably lessened by a short decubitus.

I do not claim that the patients walk well on the early

walking aid, but they do achieve a variable degree of independence, and it is this that is so important in the elderly. Finally, the cost of this system is small; it requires no more than a simple workshop (such as any day-hospital might have), and is run as an exercise in physiotherapy or occupational therapy as the case may be.

I wish to thank Mrs. Mary Morrison, lately superintendent physiotherapist, St. Helen's Hospital, Hastings, who was the pioneer in this exercise in physiotherapy.

General Practice Observed

Well-woman Clinic in General Practice

B. E. P. WOOKEY

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Summary

During a four-year period 1,169 women attended a well-woman clinic in a group practice. Eight positive smears were detected, together with one case of breast carcinoma, 94 cases of anaemia, and a number of other abnormalities. The clinic is part of a practice cervical-screening programme aimed at regular tests for women in the practice aged between 25 and 64. Patients appear to prefer attending screening clinics run by their own family doctor, and if more practices would adopt such a programme a higher proportion of the female population might be screened, and at a lower cost.

Introduction

Presymptomatic screening for cervical carcinoma and other diseases has attracted increasing attention in recent years. Despite the fact that the family doctor is the obvious person to do this for his patients, conflicting demands on his time and a lack of facilities for organizing screening campaigns have resulted in much of this work being done by local authority, voluntary, or hospital services (Donaldson and Howell, 1965; Davey, Greening, and McKinna, 1970; Seacome and Paine, 1970).

This paper describes the first four years of operation of a "well-woman clinic" as part of the regular services provided by a group practice of three doctors in a Lincolnshire market town.

Organization

The practice population is relatively stable, though the list size is slowly increasing (8,924 in June 1970). There is one central surgery, and most patients live within a five-mile (8-

km) radius. The clinic was set up in July 1966 soon after routine cytology became available in the area when demand was growing from our patients for cervical smears. We decided to provide these facilities ourselves as part of an active screening campaign in the practice for cervical carcinoma, and also to take the opportunity of performing a few other simple tests when the patients attended. During the four-year period July 1966 to June 1970 the clinic was held weekly (except during partners' holidays, etc.), and the following procedures were carried out: (1) breast examination, (2) abdominal palpation, (3) cervical smear, (4) general pelvic examination, (5) haemoglobin estimation, and (6) urine analysis for sugar and albumin.

The clinic is open to women of any age, but an active campaign has been pursued only towards those aged 25 to 64, who are encouraged to attend every five years (we hope to reduce this to three years eventually), though anyone may attend more often, and some have done so. Either our attached district nurse or our health visitor helps at the clinic, and one member of the ancillary staff is responsible for arranging appointments, sending for patients (see below), and filing results. All cervical smears taken from our patients, from whatever source, are entered on their records, on an age/sex card, and in a card index by year of the most recent smear (for recall purposes in the future).

Patients' Response

Since before its inception the clinic has been advertised by a poster in the waiting room, by word of mouth, and by the practice time table card, which most patients have. Within a year, however, numbers began to fall off and it became necessary to send notice of appointments by post, and this procedure has continued. Each clinic comprises up to six women who have made an appointment themselves and a variable number attending as a result of a letter (about 12 letters are sent each week). Each letter states the object of the clinic and offers two appointments on successive weeks, of which the patient may choose whichever is the more convenient. An initial system in which one appointment was sent produced a very poor response.

With the help of the age/sex register the letters have so far (30 June 1970) been sent to all women in the practice born

Boston, Lincs

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