Correspondence

The G.M.C. and Medical Education

SIR,—Sir Herbert Eason's helpful exposition on the functions of the General Medical Council (Sept. 6, p. 359) provides much food for reflection on a topical subject—medical education. To enable persons requiring medical aid to distinguish qualified from unqualified practitioners is the duty of the G.M.C. Does it not fail, virtually, in this primary object by leaving the British public at the mercy of rampant quackery in the form of ubiquitous and alluring advertisements of articles alleged to provide health or cures of disease? Furthermore, the public (and G.P.s) also lack any sure guide to enable them to distinguish the genuine and spurious specialist within the profession. The definition of a "specialist" is long overdue. Professional efficiency and the public weal will be served by restricting the title to one with a *guaranteed* minimum special ability in his section of healing.

The Education of the General Practitioner.—Under this heading the President alludes to three principles which prevent the Council, he says, following the lead of the Goodenough report. The interpretation of these principles seems open to question. "The Council must deal with things as they are"—i.e., a C3 nation. Granted this, we must begin at the root of the health problem—the student's curriculum—and surely the situation calls for drastic changes like those in the Goodenough report. It wants to "avoid completing after qualification incomplete instruction given before qualification." This ideal is well served by simplifying the instruction so that its inculcation in a complete form is practicable. Thirdly, the Council holds that instruction in the essentials must be adequate before the final examination. Yet to subjects of the curriculum it is recommended that new ones now be added. Since the total time is not increased, this means that something must be discarded of what was formerly regarded as essential, in order to make place for the new. The Council's judgment of essentials is shown to be changeable and open to argument.

A New Concept of the G.P.—With doubts about the effective safeguarding of the people's health it is well to review the Council's proviso regarding "things as they are" and their remedy. The G.P. is still, when health troubles arise, the beacon light on life's journey. More than ever there is room for this "guide, philosopher, and friend," but the time has come for an entirely new concept of his role in the body politic. The old legend on the brass plate of "Physician and Surgeon" is purely historical. Not only do medicine and surgery, but each of many further subdivisions, now call for separate devotees—the *specialists*—making ever sharper the contrast with the *general* practitioner. Of our growing medical knowledge a specialist knows more and more about less and less. The G.P. must know inevitably less and less about more and more; he alone maintains responsibility for the whole patient.

Think of the present preparation of the young doctor who has to assume this responsibility. His spirit as a student, confronted with mountains of medical science (of which little plays any part in daily practice), is apt to be cowed. He only learns the bulk of medical facts in order to get through examinations, and inevitably forgets it a few months after. What humbug still to inflict what has become so detailed and specialized in anatomy, physiology, pathology, forensic medicine, and the rarer diseases of medicine, operative surgery, and so forth. The student of humanity needs mainly to handle patients, be confronted with the stark facts of necropsies, and feel that what is taught is not merely highbrow but repays thorough mastery. Instead of being an exhausted wreck with an inferiority complex he will, on qualifying, feel confident, alert, lively, and "ready for the fray," albeit conscious of his limitations and unashamedly ready to seek the aid of the specialist.

Realism in Relation to Daily Practice.—First, there are common ailments that mar the health of the majority. On the eradication of these he wants to be brilliantly informed, yet they are largely ignored by "things as they are" in the curriculum. I refer to poor physical tone, mental imbalance, dental decay (87% of our best young manhood which went to France in 1939 needed dental treatment, and 12% required dentures), dyspepsia, constipation, diagnosis of cancer, rheumatism, feet deformities, etc. Secondly, there are those disorders that assail the public with relative infrequency, the importance of which his training tends relatively to magnify. Most of these are amenable to domiciliary treatment, and he needs to be not only conversant with but to acquire full competence in this, his proper sphere of therapy. Why does the Council not insist on at least one year's assistance with a reputable G.P. before independent practice is allowed? In the other subsection of the occasional ills—those more formidable enemies of the race requiring

specialists—the G.P.'s vital role is early recognition or shrewd suspicion that something serious is afoot calling for timely dispatch of the patient to the fountain-head. His concern is the deviation from health, not the minutiae of pathology. Instead, with educational "things as they are," the keen student tends to become a general pseudo-specialist. Knowledge of what health is, understanding, sympathy, and tact come not from books but by constantly being concerned with patients. What a brilliant example of this clinical approach to sickness is supplied by Sir Heneage Ogilvie's article on the "Early Diagnosis of Cancer of the Oesophagus and Stomach" (Sept. 13, p. 405). How little details of pathology and treatment figure therein, but the address reeks of humanity.

Take rectal cancer. It comes late, having been treated for many months as piles or dysentery, etc. The students needs to be taught the paramount importance of putting a finger well up the rectum in every case—i.e., regardless of the complaint or the presence of piles. Directly the parts feel unnatural he seeks the expert's opinion. And so with the slightest doubt in the breast, with haematuria, etc. Yesterday (Sept. 15) I found a cancer crater extending up into the rectum from the verge of an external pile mass. All the laconic note on the case sheet (Jan. 13, 1947) said was, "Haemorrhoids, for operation." Today a lady in the late 30s came with a few months' pain p.c., some vomiting, wasting, and bringing radiological evidence regarded as that of leather-bottle stomach. It had been put down as gastric cancer. Examination below had been deferred because of menstruation. I examined her and found a fixed, encircling growth of mid-rectum. Think of the "acute abdomen." Here the patient relies on the G.P. for an unerring sense of something surgical amiss to save fatal delay. Again, it is not so much details of pathology, but a definition of the threat of peritonitis, obstruction, haemorrhage, and so forth that the G.P. needs to recognize. Only several months' residence in hospital covers the necessary familiarity with this problem of daily practice.

The curriculum needs to be cleared of the masses of academic jargon and injected with more about the common roots of indifferently health. At the same time, by cutting the total curriculum down to 5 years, the doctor is early launched into assuming responsibility for his patients. It is then his ambition is fired and his energies readily mobilized. He quickly acquires practical knowledge safely as an assistant still under the eye of his seniors, spending one at least of the next three years with a reputable practitioner. "You can't get the terriers too soon at the rats," said Sir Robert Hutchison.—I am, etc.,

Bristol.

A. WILFRID ADAMS.

Disseminated Sclerosis

SIR,—With reference to the annotation entitled "On the Track of Disseminated Sclerosis" (Sept. 20, p. 460), I feel the following facts should be placed on record. The incidence of four cases of disseminated sclerosis in a group of seven laboratory workers engaged in studying the aetiology of a disease in sheep is an event which must arouse sympathetic regret but cannot occasion surprise. What does surprise me is the statement of the writer of the annotation that "chance has now thrown up an entirely new approach to the problem. . . ." While I agree with the writer that this may "open the way to a complete understanding of the cause of disseminated sclerosis and perhaps to its prevention and even cure," I would like to point out that the previous literature on this specific subject is completely ignored.

In a communication to the Association of Physicians of Great Britain and Ireland (published in the *British Medical Journal*, 1927, 2, 13) I referred especially to the occupational incidence of disseminated sclerosis and placed particular emphasis on farming. I then indicated that this was a channel into which inquiry might profitably be directed. The unanimity with which I was attacked convinced me of the probable accuracy and truthfulness of my observation. In 1921, Dreyfus, H. (*Z. ges. Neurol. Psychiat.*, 1921, 73, 479, emphasized the fact that the disease predominates among country dwellers in his analysis of 1,151 cases, a statement which I confirmed from my own experience (*Glasg. med. J.*, 1923, 100, 297). Boyd's *Pathology of Internal Diseases* (4th edition, 1944, p. 774, Philadelphia) refers to these observations by Dreyfus and myself, and S. A. Kinnier Wilson (*Neurology*, 1940, 1, 150, London) also records my observations on this subject. Under my direction clinical

investigation has been continued over a long period of years into various aspects of the problem, including particularly the occupational incidence of the disease, with special reference to farming. It is hoped that the results of this work on a series of 389 cases of disseminated sclerosis will shortly be embodied in a paper by a member of my staff.

Your annotation refers optimistically to the prospects of discovering the *cause* and *prevention* of this illness. At the moment I personally feel that the detection of the mode of transmission is the next most valuable step that could be made, and there is a reasonable prospect that we are approaching this state of knowledge. In 1923 I made the following statement (*Glasg. med. J.*, 1923, 100, 290): "A still further advance may then be hoped for in the detection of the mode of transmission and prevention of infection in the individual."

It cannot be assumed that the causal agent of disseminated sclerosis will produce pathological changes in the nervous system of susceptible animals identical with those found in the human subject. Equally it cannot be assumed that infection by the same agent will necessarily result in identical tissue reaction in animals of different species. As an example of this important general principle, the causative agent of "louping ill" is known to produce a separate histological picture in sheep, pigs, and mice (Brownlee, A., and Wilson, D. R., *J. comp. Path.*, 1932, 45, 67). Past experience has shown that this is an essential difficulty in attempting to transmit disseminated sclerosis experimentally to animals.—I am, etc.,

Glasgow.

DOUGLAS K. ADAMS.

Treatment of Varicose Veins

SIR.—Prof. A. M. Boyd and Mr. D. J. Robertson (Sept. 20, p. 452) discuss some of the causes of the unsatisfactory results in the treatment of varicose veins. They also illustrate their article with some very interesting phlebograms. With regard to the incidence of the condition, the authors state that 95% of patients attending civilian varicose vein clinics are women. This was certainly not the case when I had the vein clinic at St. Bartholomew's Hospital, where I found that approximately one-quarter of my cases were among men, and this figure was borne out by my private cases. I cannot agree with the suggestion that varicose veins seldom cause serious discomfort. The condition invariably develops very gradually and the patient gets used to the increasing heaviness in the limbs. Severe pain is certainly not a common feature, but the discomfort and disability are great and are aggravated by conditions which involve much standing. At the same time, the degree of discomfort is not necessarily related to the actual size or extent of the veins.

Recurrence of varicosities after treatment may mean a failure to obliterate all the incompetent veins; it may mean a gradual recanalization of veins which were obliterated at the time of treatment; or it may mean the gradual development of varicosities in other veins. My own experience has led me to an operation—a combined excision and ligation—with at least two, and possibly three, incisions in the thigh and with two incisions in the calf, with a further large popliteal incision where the external saphenous vein is involved. Subsequently, any small remaining veins are treated by injections. At the same time I do not believe that the mere ligation operation at sites of valvular incompetence of communicating veins will secure obliteration of extensive varicosities, even when combined with simultaneous injections. By suitably planning the direction of incisions it is possible to use the flexure lines of the skin, to get adequate exposure of considerable lengths of the veins, and to avoid incisions in the long axis of the limbs. In one week recently I saw three patients all of whom had had recent ligation and injection operations at the groins, and all of whom showed complete incompetence of the whole saphenous systems right up to the level of the operation scars. Neither the symptoms nor the signs suggested that there had been any appreciable alteration as the result of the treatment.

Operative experience also suggests that by far the most important deep communicating vein is the one situated at the junction of the middle and lower third of the leg as a communication between the internal saphenous vein or one of its branches and the deep veins. Certainly, from the point of view of local symptoms, the failures of injection treatment, and the

local complications such as eczema, ulceration, etc., this is the branch which is so often responsible for a reflux of blood into the superficial veins. The presence of this vein can often be inferred from the physical signs but cannot be proved until operation is carried out.

Prof. Boyd states that between October, 1942, and February, 1943, he saw 12 patients with deep thrombosis following injection treatment in the Army. I am not quite clear from the context whether these patients had had a combination of operation and injections or injections alone. In my own series of approximately 2,000 varicose vein cases I have never seen this complication following operation, operation and subsequent injections, or injections alone. On the other hand, whatever form of treatment is adopted, there are cases which show temporary and transient oedema, particularly on the inner side of the foot and ankle, for some weeks after treatment. This is much more likely to occur where there is much subcutaneous tissue, where operations have been extensive, or thrombosis has been widespread, but I have never known this oedema persist. The proper treatment, of course, is to control the oedema with external support, and, as lymphatic function is re-established, gradually to lessen the external support. In view of what Prof. Boyd says about the reaction of men in the Army to varicose veins, I am wondering if some of the deep thrombosis cases were really post-treatment oedemas and not deep thromboses at all. The presence of an abdominal collateral circulation would be conclusive. The authors suggest that this complication of deep thrombosis may have been due to the passage of injection fluid into the femoral veins, where the circulation may be sluggish. I am sure that some of the sclerosing fluid must get into the deep veins following injections, but there are two comments I would like to make in this connexion. The first is that the more normal the structure of the vein wall, the greater the difficulty in getting thrombosis with sclerosants. And, secondly, that in those patients who have a slight sensitivity to quinine the drug is tasted within approximately 15 to 20 seconds of injection of the peripheral veins of the lower limb with the patient lying down.

London, W.1.

REGINALD T. PAYNE.

SIR.—Prof. A. M. Boyd and Mr. D. J. Robertson's most interesting article on the above subject (Sept. 20, p. 452) calls attention to the unsatisfactory results of the treatment of the all too common varix. I feel that their conclusions tend to advise a standard treatment of varicosities needing surgical care. They state: "Ligation is required at four sites . . ." "High retrograde injection of large quantities of . . . sclerosant is dangerous," etc. I submit that each case of severe varices needs a careful assessment and that varied treatments are called for according to the findings at the time of examination. The Ochsner-Mahorner tourniquet test will tell the operator the site of the incompetent communicating veins. Four standard sites of ligation will then not be found necessary in the majority of cases. For instance, in a large series of cases these surgeons found that it was only necessary to ligate the saphenous below the knee in 2% of patients.

Again, to condemn the use of retrograde injection of a sclerosant into the distal portion of the internal saphenous divided at the fossa ovalis is far too sweeping a statement. If the patient has suffered from an antecedent deep-vein thrombophlebitis care should be observed regarding the use of any sclerosant. Has there been a recent superficial phlebitis? In these cases use no sclerosant if a severe reaction is to be avoided. There are other indications for the modification of the type and amount of sclerosant to be used. The "mid-Hunter blow-out" (aptly named by various American surgeons) is, as proved by Prof. Boyd and Mr. Robertson, responsible for the admission of much sclerosant into the deep system. The careful use of a Stevenson needle (or one of its modifications) can mitigate this risk. Again, hypertonic saline in the hands of Harold Dodd has satisfied him and many others that damage to the normal intima does not occur.

In a short letter I can but endeavour to point out that standardized treatments and dogmatic statements cannot be applied to the vagaries of the varix. It is seldom that two cases present exactly the same problem. The authors of the article under discussion are, however, to be congratulated on calling attention to the fact that the treatment of varices can be