I know that at present an examination is only one of several proposed criteria for membership, but its inclusion in the list at all represents the thin edge of a very ominous-looking wedge. It would be tragic indeed if those who seek by an examination to enhance the prestige of the College succeed only in degrading it. All family doctors should be welcomed into the College and when they have gained experience in family doctoring—which is not obtainable from books or examinations—they will automatically play their part in furthering its cause and enhancing its prestige. By such means we shall raise the general standard of family doctoring practised throughout the country—and the College's role will not be restricted merely to that of comforter and friend to those who already practise good quality medicine.—I am, etc.,

Winchester, Hants.

RONALD GIBSON.

Risks of Smallpox Vaccination

SIR,—The letters of Dr. Ian Taylor and Dr. E. James (January 19, p. 193) call for comment. That of Dr. Taylor points out that many fear that the difficulty of re-educating parents to seek smallpox vaccination during the second year of life may result in many children remaining unprotected who would otherwise have been vaccinated as a natural sequel to the course of triple immunization in infancy.

An important point arises in this connexion: in immunology the theoretically ideal procedure often has to be sacrificed to some extent to practical considerations. For example, injections of triple prophylactic against diphtheria, tetanus, and whooping-cough would produce a somewhat better response if given at intervals of six weeks as opposed to the generally utilized monthly interval. The latter is usually adopted, however, as not being too long drawn out, so that a larger number of infants complete the course without defection.

Sudden reversals of policy, such as discontinuance of oral poliomyelitis vaccine, the change in vaccination recommendation, and the like, raise a serious point. What confidence can parents be expected to have in our profession if we are continually chopping and changing our advice to them on the slenderest scientific evidence? Confusion must obviously be greater when one area administration takes note of the latest statistical scare and alters its policy, whilst a neighbouring district refuses to be stampeded and continues as of yore. Surely our job is to find a procedure which works with reasonable safety (as did our recent vaccination routine when time was available for the exclusion of infants with an unsatisfactory personal or family history) and, having found it, to stick to it. None of the morbidity or mortality figures for vaccination against smallpox at any age take into account the fact that a carefully taken history would have excluded a number of these subjects from vaccination. Mistakes do occur under pressure: I have made one myself, but by and large I am convinced that the exclusion of unsuitable subjects would get rid of most of the vaccination scare.

It is of course quite unsound to argue that because vaccination at certain ages produces a morbidity or mortality greater than does smallpox, therefore the procedure should be abandoned or postponed till some time when it will probably never be undertaken. What would the position be if smallpox really got loose in a relatively unvaccinated population? The present boggy of vaccination at 6 months of age would vanish like a

snowflake in Hades in the face of a recrudescence of smallpox to which some misguided statistical deductions seem to open the door.

Statisticians can prove an awful headache to those who are trying to do a real job of work. There may be some who remember my (at first) almost lone battle to save diphtheria prophylaxis following the statistical reports on post-injection paralysis. Nothing on this earth can be absolutely safe, and the slight risks of any procedure must always be weighed most carefully against the obvious advantages before indulging in any *volte-face* of policy.

As regards the letter from Dr. E. James, I do heartily agree with him that we ought to restrict our efforts to the control of diseases which are killers or maimers. The measles experiment was interesting, but I doubt if it needs further investigation, at any rate as regards this country.—I am, etc.,

Broadbridge Heath, Sussex.

GUY BOUSFIELD.

Detection of Glaucoma

SIR,—The statistics recently quoted in your columns (December 22, p. 1680, etc.) indicating the extent of the failure to diagnose and treat glaucoma before certifiable blindness has resulted could be supported by other similar evidence of late inadequate diagnoses in respect of cataract, retinal detachment, diabetic ocular changes, and many other causes of blindness. Collectively they constitute a formidable indictment of the ophthalmic provisions of the National Health Service, both its inadequacy and (more important) the complacency which prevails about it.

Those of us who work in this service accepted as inevitable the makeshift arrangements hurriedly introduced in 1948 on the understanding that they were a temporary expedient and that the Hospital Service would be progressively expanded to embrace all Health Service ophthalmic work. Subsequent experience has shown that this would require the Hospital Ophthalmic Service to be trebled or quadrupled in facilities and staff. After 15 years practically nothing has been achieved in either direction; hospital ophthalmic departments are still hopelessly inadequate, but no one seems to care very much about this any longer, and the increase in ophthalmic consultants has not only fallen short of the expected expansion, but at 9% is the lowest in any specialty in the Hospital Service.

No other section of the Health Service is content that three-quarters of the consultations shall be carried out by technicians who are not medically qualified at all and whose medical experience is exceedingly limited. Would E.N.T. surgeons accept a system which permitted patients direct access to deaf aids without medical examination? Would dentists agree in respect of dentures, surgeons in regard to trusses, and physicians in respect of medicines and appliances? Would we be surprised by the statistical results if they did?

No one seems anxious to seek to implement a logical scheme by which all patients with ophthalmic symptoms would be referred by general practitioners who considered it necessary to a doctor with special ophthalmic experience for examination and, after examination, for the provision of spectacles if necessary. Refraction is an integral part of an ophthalmic examination and spectacles the by-product. If it is unavoidably necessary, refraction can often be postponed or delegated after medical examination; but it cannot be substituted for it

without the disasters which are now becoming apparent, and these are not always immediately to be seen. No ophthalmic service can ever be accepted as adequate until this principle is maintained, but we are moving away from this ideal, not towards it. It does not suit the convenience of anyone concerned to seek to amend the present lamentable system; patients like it because it is there; it is so convenient to procure glasses without waiting, without appointment, and with full commercial treatment, by-passing a tiresome medical examination. They are quite unaware of the risks they run until it may be too late. General practitioners find it easy and convenient to issue form O.S.C.1 (once for a lifetime) as there is no bother about letters or arranging appointments. Hospitals have no wish to see their ophthalmic departments quadrupled in size, and ophthalmologists tend to be content to capitalize their scarcity by choosing the most interesting and challenging aspects of their duties and leaving the routine chores undone.

Can we expect any substantial number of opticians to wish to move into the Hospital Service when a competent sight-tester with an established business can already earn far more than a consultant ophthalmologist? It is sometimes alleged that the present service must be good because there are so few complaints. It is in fact almost impossible to make an effective complaint except for manifest fraud; there is no requirement to make a patient "optically fit"; no regional ophthalmic officer comparable to the regional dental officer; no spectacle-testing scheme comparable to the quality control of drugs; and there are so many loopholes, like the intolerance provision, that suspected incompetence is extremely hard to prove. As a last resort an optician can, and sometimes does, give a patient his money back, which apparently ensures that justice has manifestly been done; the patient, however, is unaware that the optician has been paid anyway by the Health Service.

There are constantly manœuvres afoot to eliminate form O.S.C.1 altogether, to make the Supplementary Ophthalmic Service a permanent one, to grant opticians semi-medical status by permitting them the right of direct reference to hospitals over the heads of general practitioners, and refraction is being established as an end in itself and not merely as part of a proper medical clinical examination. If this trend continues the general practitioner will have been virtually eliminated from the procedure entirely and the whole ophthalmic service will pass almost entirely into the hands of laymen. The statistics already tell their own tale. It is vitally important that the whole system should be radically revised before it is too late, that ophthalmic medical examinations should be made an essential and not merely an optional feature of a sight test, and that glasses should not be supplied without prior adequate examination for which opticians are not now and never will be adequately trained, for early diagnosis is often the most difficult of all. If this is not so, what is the point of training ophthalmologists at all? Are they in the future to occupy themselves almost exclusively in operating upon the prematurely and unnecessarily blind?—I am, etc.,

Lincoln County Hospital,
Lincoln.

ALLAN H. BRIGGS.

Orotracheal Intubation

SIR,—Dr. C. Langton Hewer, as usual, has hit the nail on the head in condemning endotracheal intubation under inadequate anaesthesia (January 5, p. 53).

One gains the impression that cases of cardiac arrest associated with anaesthesia have increased alarmingly over the last three or four years. The sequence of events seems to be: ineffective premedication, an inadequate dosage of intravenous barbiturate, suxamethonium given solely to facilitate a quite unnecessary intubation, followed by forcible ventilation of a, by now, "bucking" cyanotic patient with a mixture containing a high percentage of halothane vapour; sudden cardiac arrest. The part played by the last-mentioned anaesthetic is strangely reminiscent of another halogen derivative—chloroform, also powerful, not inflammable, and fatally easy to administer. If one deliberately wanted to stack the cards against the patient, one could hardly "improve" on the above technique, and yet this is fairly common practice to-day.

It is high time we returned to sanity and the basic principles seemingly abandoned in the last few years: the concept of balanced anaesthesia with adequate early analgesia and hypnosis; intubation performed only when necessary and not for every perineal and limb operation, and controlled respiration practised solely with an innocuous mixture of nitrous oxide and oxygen, not with a potentially lethal mixture.

Lastly, in the control of respiration, attention seems to be focused on the motivating apparatus and very little on chest movement. It is all too common to see "ventilation" performed manually or mechanically with a half-open expiratory valve, plenty of "respiratory" noise, and practically no chest movement at all.—I am, etc.,

London W.6.

P. G. AZZOPARDI.

SIR,—Like Dr. C. Langton Hewer I have followed the correspondence on "Anaesthesia for Burns" with considerable interest, and thoroughly agree with his observations regarding intubation under inadequate anaesthesia (January 5, p. 53). I wonder, however, whether the brief period of apnoea—sometimes not so brief—following the injection of suxamethonium may not also be a contributory factor in the causation of vaso-vagal syncope during or shortly after intubation? Breath-holding may be relatively harmless when a patient is in good general condition, but even a short period of apnoea may be too much for a patient suffering from toxæmia or shock due to burns or other cause.

Recently I asked the anaesthetic nurse to note the time taken to carry out the various manœuvres of intubation in some of my own cases following induction with thiopentone and suxamethonium. After inflating the lungs with oxygen, it then took 20 seconds to pick up the laryngoscope and expose the glottis, 5 to 15 seconds to insert the tube into the trachea, and 15 seconds to make the necessary connexions to the anaesthetic apparatus—a total of 40 to 50 seconds. Even for a healthy patient this is quite a long time to stop breathing, and the fact that the colour remains pink is not necessarily an indication that all is well with the circulation. I regard myself as a reasonably consistent (though by no means infallible) laryngoscopist, so 40 to 50 seconds is probably a fairly average time for intubation, though no doubt many anaesthetists can improve on these figures; on the other hand, there are occasions when intubation may be difficult, or the anaesthetist inexperienced, in which case the period of apnoea may be considerably longer.