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In many hospitals general practitioners are not allowed to perform D and C's, let alone other procedures that may be slightly more complicated. A private census taken in one of the larger cities of Canada showed that the average general practitioner was getting no more than two beds a month. Many hospitals in North America do not allow a general practitioner through their doors.

The general practitioner has been cut down at every turn, and in my opinion ruthlessly, so that he practises in many places without dignity.

Dr. Rising's article advocates further education for the general practitioner. It is obvious that all the general practitioner is going to do is to educate himself and not be rewarded for it in the medical community—that is, no increased admitting privileges or surgical opportunities in the hospital will be awarded following this additional training.

Unfortunately, it is all too obvious that the problem comes down to an economic one. If those in control of the hospitals were able to see that they could increase their own earnings by once again giving the general practitioner free access to hospital facilities, I believe that he would be given all the opportunities in the world. Unfortunately, this is not the case.

What then may the medical student look forward to after six to eight years of university and one or two years of internship? General practice?—obviously not, unless he wants to be a high-class first-aid man in a busy office and nothing more.

If educators and specialists are honestly interested in persuading more physicians to become general practitioners, let them raise their voices and tell their confrères, as well as medical students, that decent admitting privileges will be made available to all in all hospitals, and that their rights will be respected. Let them also say that procedures may be open to them once again, according to their ability, and that opportunities will be afforded them so that they may develop further skills and that they will be allowed to make use of them as they continue in their practices.

I would not close this letter without expressing gratitude to the hospitals and specialists in the small city in which I am conducting my practice. Here a general practitioner is given adequate and fair admitting privileges and he has surgical privileges as dictated by fair judgment of his confrères and his own ability. How long this will last is hard to say.

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CANADIAN UNIVERSITY SERVICE OVERSEAS

To the Editor:

I am writing to you at this time to send you some brief information on our organization which you might wish to bring to the attention of interested members of the medical profession.

The Canadian University Service Overseas (CUSO) is a private organization which is similar in many ways to the United States Peace Corps. Established in 1961, CUSO is now supporting 201 volunteers overseas in 23 countries in Africa, Asia, the Caribbean and South America. Qualified Canadian graduates of all professions are recruited to serve overseas in developing countries at local, rather than expatriate, conditions of service. At the present time there are two doctors, 19 nurses, one physiotherapist and one laboratory technician serving in this program.

There are numerous opportunities for qualified doctors to serve overseas in rural health units and in general hospitals. At the present time, one of our doctors is serving in a hospital and leprosarium in Eastern Nigeria and the other doctor is acting as a regional medical officer in Tanzania.

Anyone interested in applying for service overseas should contact the CUSO Committee at the nearest Canadian university or college, or should write to the Executive Secretary, CUSO, 75 Albert Street, Ottawa 4.

WILLIAM MCWHINNEY,
Executive Secretary

AMINOPYRINE, DIPYRONE AND AGRANULOCYTOSIS

To the Editor:

The editorial on this subject (*Canad. Med. Ass. J.*, 91: 1229, 1964) listed several products containing aminopyrine, or the derivative dipyrone, and recommended that untoward reactions to these agents be reported to the Food and Drug Directorate. May I suggest that phenylbutazone, a cogener of aminopyrine and antipyrene, be added to this list?

Reference to the literature[1, 2] shows similar reported side effects and molecular structure and confirms that this is another instance of an old drug under a "newer" label.

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REFERENCES

1. MODELL, W. editor: Drugs of choice, 1962-63, 3rd ed., C. V. Mosby Company, St. Louis, 1962.
2. STECHER, P. G. *et al.*: Merck index of chemicals and drugs, encyclopedia for chemists, pharmacists, physicians and members of allied professions, 7th ed., Merck & Co. Inc., Rahway, N.J., 1960.

EFFECTS OF ETHAMIVAN IN PATIENTS WITH CHRONIC RESPIRATORY DISEASE

To the Editor:

The authors of the paper, "Effects of Ethamivan in Patients with Chronic Respiratory Disease" (B. J. Sproule, R. L. Jans, H. Brietkreutz and W. Mahon: *Canad. Med. Ass. J.*, 91: 1203, 1964), would like to express their gratitude to Dr. J. D. Taylor, Department of Pharmacology, University of Alberta, for directing the development of techniques for the measurement of blood ethamivan.

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ERRATUM

In the abstract of the article entitled "Effects of Ethamivan in Patients with Chronic Respiratory Disease" by B. J. Sproule *et al.*, published in the issue of December 5 (*Canad. Med. Ass. J.*, 91: 1203, 1964), the dosage level was stated to be 25 mg./kg. The correct figure is 2.5 mg./kg.