be unfair on some, I believe it would do more than any other suggested reform to ensure that the examination is a fair test of current clinical medicine.—I am, etc.,

A CANDIDATE.

Parkinson's Law in Medicine

SIR,—It is heartening to find Dr. Henry Miller (March 3, p. 630) defending the younger generation against the deadening hand of examinations that threaten to extinguish initiative and originality. Gleb V. Anrep, one of our most brilliant extemporizers in physiological research, used to tell the sad tale of a Russian composer who lamented that when he was young he had brilliant musical ideas but no technique, while when he was old he had the technique but no longer the ideas. So it will be with our younger generation, handicapped by the surfeit of examinations devised by our plethora of colleges.

Thirty years have seen the establishment of a College of Obstetricians and Gynaecologists, now almost sacrosanct because of the royal insignia, and of a College of General Practitioners, fortunately not yet protected by the accolade, but already proposing to add to the examination burden. We can expect a College of Oto-Rhino-Laryngologists, with the sequel that its diploma alone will authorize some greybeard to mop out an ear or prescribe for a pair of inflamed tonsils. Parkinson's Law in a new disguise is indeed overtaking our once proud and independent profession, and the rot seems to be developing from within.—I am, etc.,

South Molton, Devon. R. A. NASH.

G.P. Maternity Units

SIR,—Dr. T. A. Best (March 3, p. 631) suggests that a monthly meeting attended by all concerned in running a maternity unit would result in an improvement in the general standard of obstetrics. In this hospital a monthly clinico-pathology meeting has been held for many years and a monthly clinical meeting since the inception of the professorial unit. One fact that emerges very clearly is that death *in utero* from hypoxia is three times as common as death from birth trauma.

Dr. Best implies that most primigravidae, including those over 30, can be looked after in the G.P. units. I have recently completed an analysis of pregnancy and labour in 750 primigravida, 260 of them over the age of 30, delivered in this hospital. Approximately 1 in 5 of these patients were delivered by caesarean section and 1 in 4 with forceps, foetal distress being an indication for 30% of the sections and 20% of the forceps deliveries.

I would submit, therefore, that the place for confinement of any primigravida, especially those over the age of 30, is in hospital where operative delivery can be performed promptly when necessary, as it will be in almost half the elderly primigravidae. This requires an adequately equipped theatre with highly trained staff, an immediately available anaesthetist experienced in obstetric anaesthesia, and efficient means of resuscitation of the newborn, preferably by a paediatrician. While it may be argued that this is the ideal and that not all hospitals at present fulfil these requirements, surely this means that we must improve our hospitals rather than advocate more units which can never give full facilities for emergency obstetrics. It would be a great pity if a situation which has arisen due to inadequate hospital accommodation were to be exploited to convince the expectant mother, often against her better judgment, that she and her baby are as safe in a G.P. unit as they would be in hospital. It must be realized that the outcome of any pregnancy or labour cannot be accurately anticipated, for abnormalities can arise within a space of minutes, however efficient the attendants may be. When anaesthesia and major surgery are needed, and forceps delivery can often be included in this category, there is no place for their performance outside a hospital any more than for an emergency gastrectomy on the kitchen table by an "occasional" surgeon.

Finally, if pregnancy and labour are as safe as one is led to believe, why are there over 350 maternity flying-squads in this country and why are so many doctors' children born in hospital? Can it be that the minimum of 10 years' postgraduate training before consultant status is reached is a little more reassuring than the experience of the G.P. obstetrician however keen, albeit frustrated, he may be?—I am, etc.,

Queen Charlotte's Maternity Hospital, London W.6. R. T. BOOTH.

SIR,—The need for nation-wide consultant cover of confinements at home has been acknowledged by acceptance, on paper at any rate, of the principle that effective obstetric flying squads should be available everywhere.

Might not these now evolve into mobile obstetric teams, capable among other things of performing caesarean sections in G.P. maternity units? Presumably it is the possibility of caesarean sections becoming necessary that makes the committee of the R.C.O.G. (February 10, p. 391) designate so many categories of cases as generally "unsuitable for confinement in a G.P. Maternity Unit." Doubtless an obstetrician prefers to perform a caesarean section in familiar surroundings, but would he not be agreeable to doing them elsewhere if he had an anaesthetist and theatre sister or technician in his mobile team?—I am, etc.,

Barton-on-Humber, Lincs. S. H. F. HOWARD.

Clinical Responsibility

SIR,—I wish to associate myself with Dr. D. L. Williams's sentiments as expressed in your columns (February 17, p. 470).

The unhappy thought that strikes me is that the powers-that-be in obstetrics are finding it necessary to lower the clinical level of liaison between consultant and general-practitioner obstetrician. Indeed, liaison has dramatically changed to "direction" recently. Witness the following: (*a*) The general practitioner will do five post-natal visits—or lose two guineas. (*b*) "Booking committees" of G.P. maternity units (February 10, p. 391) will refuse bookings from doctors for patients in certain obstetric categories. I agree entirely with these categories, but the method of obstructing the general practitioner in this instance savours of antagonism and distrust.

However illuminating an analysis into maternal deaths, etc., may become, one stark fact is that without adequate resident obstetric house-officers consultant units would become very inefficient. During the past eight to ten years applications for these posts have established an almost cut-throat competitive element. Why? Because (i) "Obstetric experience essential" loomed largely in most of the advertisements for

assistants in general practice. (ii) To gain entry on the Obstetric List. (iii) Most doctors who intended practising midwifery felt woefully ignorant and inept —certainly on the practical side.

I would suggest that for the future general practitioner these reasons are nowadays obsolescent, and that in fact there is only one logical reason for doing a house-post in obstetrics—namely, the desire to specialize. Admittedly there is extra remuneration for the "Obstetric List" doctor, but when one's clinical responsibility becomes whittled away, and authority decrees whither, when, and how, a matter of five guineas *per caput* is of little consequence.

Sooner or later young doctors will realize that resident obstetric posts are pointless; older doctors will also realize that to advertise "obstetrics essential" is equally pointless. When that happens the maternity service as we know it will be in danger of breakdown. It would be an ironic twist of autocratic planning if at some future date, when everything has been centralized, it was found necessary to decentralize owing to shortage of junior medical staff in obstetric units.—I am, etc.,

Ruthin, Denbighshire. T. M. WINSTANLEY.

Why the Pool?

SIR,—I was pleased to see that the views expressed by Dr. Frank E. Gould (March 3, p. 634) are in accordance with what I have long felt regarding the "Pool" system of payment. If an industry decided that overtime wages would be levied by a deduction from normal wages, how long would the employees tolerate it? I can see no difference between this and a reduction in capitation fee consequent to other demands made upon the Pool.

The fact that our financial status is tolerable at the moment should not make us tolerate a system of payment which amounts to dishonesty on the part of the Government. No doubt the Government is aware that any professional body which is prepared to acquiesce to such imposition will also meekly submit to more and more clinical direction. If we are not prepared to insist upon a just method of payment *first*, I doubt if our protests against clinical direction, etc., will be given any serious consideration.—I am, etc.,

Belfast. J. D. H. MAHONY.

Lost Generations in British Surgery

SIR,—Dr. J. R. Seale takes me to task (February 10, p. 389) for suggesting that there has never been so much medical talent available for the British public. But what are the facts? Last year 140 British doctors obtained permanent residence visas in the United States.[1] During 1960, 287 doctors migrated from the United Kingdom to North America.[1 2] Some are possibly packing their bags at this moment. Here is a galaxy of medical talent available for the British public if only they can provide reasonable terms and conditions of service.

Dr. Seale claims that it takes 15–20 years to train a surgeon. In the rest of the English-speaking world it takes only 10 or 11 years. Can it be that considerations other than training form part of the British surgeons' 20-year apprenticeship? Inspecting the Royal Commission Report,[3] I find that the pay scales for senior registrars are marked—£2,100 for 9th *and any subsequent year*. We must assume that some will serve as registrars "in training" for 13 or more postgraduate years. Can anyone doubt that our alleged consultant shortage would vanish if our training programmes were brought into line with those existing abroad? It is little wonder that there is difficulty in finding men who are prepared to give hostages to this type of fortune.—I am, etc.,

Worthing, Sussex. RICHARD H. DAVISON.

REFERENCES

1 Information Services, U.S. Department of Justice, Washington, 1962.
2 *Annual and Quarterly Statistical Reports of Department of National Health and Welfare*, 1960 and 1961. Ottawa.
3 *Royal Commission on Doctors' and Dentists' Remuneration, 1957–60*, 1960, p. 255, Table 36, Cmnd. 939. H.M.S.O., London.

Postgraduate Medical Education

SIR,—We suggest that house-jobs at undergraduate teaching hospitals should all be made into post-registration appointments. This would be advantageous for the following reasons.

(1) Postgraduate training is at present being developed in non-teaching hospitals. We believe that the staff of teaching hospitals should care for the undergraduate and postgraduate phases of medical education, while the general physicians and surgeons at non-teaching hospitals should assume responsibility for the pre-registration year. The usual distribution of clinical material between the two types of hospital favours an apprenticeship in clinical responsibility at a non-teaching hospital, followed by postgraduate work in the more theoretical and specialized atmosphere of a teaching centre.

(2) There is a shortage of good post-registration appointments, as shown by the fact that those at the Whittington Hospital are each contested by sometimes as many as 60 applicants. This state of affairs has been aggravated by the termination of National Service. The problem of what to do after two pre-registration house jobs is a very real one; there is a handful of appointments where good postgraduate training is available, and the usual advice given by teaching hospital staff is to go out to a non-teaching hospital for a while, to gain experience. Such hospitals are often not ideal for working towards the higher degrees which many feel obliged, for various reasons, to seek as little as 18 months after qualification. Teaching-hospital house-jobs, frequently with a high staff-to-patient ratio and good library and training facilities, would, however, be well suited to postgraduate study, whilst holders of such appointments could play a more useful part in undergraduate education than at present.

(3) The increased number of post-registration appointments made available would encourage more doctors to seek such posts at their own or some other teaching hospital before going into general practice. This would help to relieve the present shortage of junior medical staff, and might also improve the standard of general practice.

(4) At present the ablest students qualifying at any teaching hospital are retained for pre-registration appointments; the dissemination of these throughout the country would raise the standard of such posts in non-teaching hospitals.

(5) We feel it to be desirable that those entering general practice immediately after registration should have at least one year's hospital experience outside their