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Pointers

Chronic Renal Failure: A 70-kg. patient is found to need about 35 g. of protein a day to remain in nitrogen balance, so reduced protein diets should be used for only short periods if other treatment is available (p. 735).

Mortality among Widowers: During first six months of bereavement deaths in widowers aged 55 and over were 40% above the expected rate, the increase being mainly from coronary thrombosis and other cardiovascular disease (p. 740).

Acidosis in Diabetes: Lactic acidosis can contribute to diabetic metabolic acidosis, and may even replace the ketoacidosis during treatment (p. 744).

Metabolic Response in Three Ethnic Groups: Whites, Indians, and Africans had different metabolic responses to an oral glucose load (p. 748).

Calcium and Diuretics: Oral frusemide produced hypercalciuria in 14 normal volunteers, possibly owing to decreased tubular reabsorption (p. 751).

Gram-negative Septicaemia: Hypophosphataemia considered a valuable diagnostic aid, particularly if previous antibiotic treatment has made it hard to demonstrate causative pathogens (p. 753).

Ulcerative Colitis: Majority of 200 patients treated by resection and ileorectal anastomosis now lead normal and satisfactory lives (p. 756).

Renal Transplantation: Cytotoxic antibodies detected (p. 758).

Case Reports: Premenarchal pregnancy (p. 760); familial thyrotoxic periodic paralysis (p. 760).

Medicine in the Tropics: Fever in children (p. 761).

Need for Doctors: Is medicine getting too big a share of the available talent? (p. 769).

Training of Psychiatrists: Conference (p. 773).

Personal View: Dr. George Day (p. 775).

Letters: On immigrant doctors, economics of renal dialysis, Abortion Act, overinvestigation, tetracycline and nystatin, and G.P. hospital beds (pp. 776–785).

"Acta Medica Scandinavica": Centenary (p. 731).

Annual Clinical Meeting, Malta, G.C.: Programme (*Supplement*, p. 103).

Overseas Doctors: B.M.A. seeks discussion with Government on medical immigration (*Supplement*, p. 106). Leader at this page.

Doctors' Pay: Hospital medical staff and preclinical teachers (*Supplement*, p. 107).

Doctors from Overseas

For many years the hospital service in Britain has relied on doctors from overseas to fill about 40% of the junior posts, and while they could get jobs fairly easily the system worked smoothly. Recently, however, the equilibrium has been upset. Many overseas graduates are now finding it almost impossible to get jobs. Hospitals which two years ago had great difficulty in filling junior posts now have as many as 100 applicants for one appointment; and some of these doctors spend months unemployed. Factors responsible for the changed situation include the stricter immigration policy of the U.S.A., the rising output of medical graduates from British medical schools, and an overall increase in the number of doctors coming into Britain each year, particularly from the Middle East—in 1968 the number of doctors from Egypt and Iran was about equal to that from Australia or Pakistan.

While the N.H.S. has been short of doctors successive Governments have done nothing to restrict the flow of doctors into Britain. Those who come as postgraduate students are not subject to immigration quotas, but they must return to their home countries when their permit expires at the end of a year unless it is renewed. But immigrant B vouchers, which give the holder a right to permanent residence in Britain, seem to have been freely available to any doctor from any Commonwealth country. As a result some doctors have been admitted as permanent immigrants with degrees not acceptable to the General Medical Council—and unless they are prepared to sit for a British qualification these doctors cannot practise here. Many doctors are admitted from India and Pakistan with degrees recognized by the G.M.C. but without the criteria necessary for full registration. These unfortunate people find themselves in competition with British graduates for preregistration posts, which are in increasingly short supply. Doctors from countries with no reciprocity agreement with the G.M.C. are eligible only for temporary registration, which has to be renewed every time a new post is obtained.

Few overseas graduates come to Britain with a personal introduction or an appointment already secured. Most arrive with little money (owing to the currency laws of their own countries) and they must therefore find paid employment quickly. The voluntary assessment scheme started by the Ministry of Health has been a failure. A month is a short time to assess anyone, and no provision was made for finding suitable jobs for doctors at the end of their period of assessment. So most newly arrived immigrant doctors have had to find work without any references other than those they brought with them.

Within the hospital service there is a shortage of junior appointments which combine good training with good prospects for further advancement. A recent tightening up of the regulations for postgraduate examinations by the Royal Colleges has further emphasized the division between training posts that are worthwhile and those that are useless. No society in the world would give the best jobs to unknown foreigners while good

native applicants came forward: hence very few unsponsored overseas graduates get the sort of jobs they would like. Most hospital junior appointments are in regional hospitals, and unless the hospital is formally linked with a teaching hospital training is likely to be limited to practical experience; a good reference at the end of the job is a passport only to another job of the same kind. In practice, therefore, the good training posts are filled by British graduates while the service needs are carried largely by overseas graduates. This is not the result of racial discrimination by hospitals, for coloured graduates of British medical schools meet little prejudice. Some junior posts are in unpopular specialties, such as geriatrics in decaying hospitals in depressed industrial areas; and it is not surprising that such posts are filled by the applicants who are least equipped to compete for the better posts—often after months of failure to find anything else.

The inescapable conclusion is that junior appointments in many industrial areas are so unattractive that British graduates will not consider them. This fact has had wide publicity, but nevertheless large numbers of overseas doctors are prepared to come to Britain knowing what sort of jobs they are likely to get. This cannot fairly be called exploitation. Medical immigrants enter Britain voluntarily, and they earn more here than they would in their home countries. Furthermore, many overseas graduates are now applying for vacancies in general practice and for consultant appointments, indicating that, for some at least, practice in the N.H.S. is preferable to returning to their own countries, where so often there is a desperate shortage of doctors.

Free movement of doctors around the world is an essential and traditional feature of medicine, and the opportunities for it have never been better. Postgraduate students are always welcome in Britain; and if doctors from abroad care to try to make a career here good luck to them. But the existing situation—a rising pool of unemployed overseas doctors and a widening gulf between jobs which are worth while and those that can be filled only from the unemployed—should not be allowed to deteriorate. A consultant in a northern mill-town is often faced with the choice of no houseman or one with no previous experience in Britain and with a poor command of English. Should he take on such a candidate, hoping to find him a useful pair of hands while he learns English? Whose responsibility is it if a tragedy occurs because of misunderstanding or failure in communications?

The B.M.A. Overseas Committee discussed these problems at its last meeting (*Supplement*, p. 106) and has asked for talks with the Government as soon as possible. Three steps can and should be taken at once. Firstly, no doctors—except approved postgraduate students—should be allowed into Britain unless their qualifications allow them to be fully registered by the G.M.C. either temporarily or permanently. Secondly, some screening test of knowledge of English and medicine, similar to the American E.C.F.M.G. examination, should be required for all medical immigrants. Finally, appointment committees should refuse to appoint unsuitable applicants to posts in the N.H.S. If no applicants are suitable the conditions of the post must be improved until it attracts candidates of adequate calibre. The state of the hospitals is the Government's responsibility. In the long term it is better that a hospital or a department should close down for a period than be run with poor staff. Only action of this kind will bring home to the public that much of the hospital service is what Mr. Walpole Lewin recently described[1] as "a crumbling edifice."

[1] *Brit. med. J., Suppl.*, 1969, 1, 88.

Peril on the Sea

Trawler fishing and its hazards, the mortality and morbidity of the fishermen, and the medical services provided for them between 1963 and 1965 at Grimsby have recently been described in two articles[1 2] by S. R. W. Moore. The author himself went to sea, and the articles give a vivid picture of conditions in the trawling fleet. Moore found that, though the accommodation was almost within the requirements of the international convention, quarters were cramped, noise and vibration reached all parts of the ships, and the continuous movement of these vessels was a frequent cause of accidents.

At Grimsby and some other fishing ports there are dockside medical clinics which provide treatment for sick and injured fishermen. At sea the medical care of the crew is the skipper's responsibility. Both skipper and mate hold first-aid certificates, and the vessel carries a medicine chest and a copy of the *Ship Captain's Medical Aid*. The skipper may ask for medical advice or summon aid by radio telephone either from the shore or, until recently, from the Icelandic Fishery Protection Patrol ships, or he may put into port to land a sick or injured man. During 1963 a naval vessel gave advice 56 times to Grimsby trawlers and the medical officer boarded 24 times; 165 Grimsby fishermen were put ashore, 143 at foreign ports, and of these nearly twice as many had injuries as illnesses. In this year there were 14 deaths, three from drowning, two due to suffocation during a fire, one from head injuries, and eight due to natural causes. In a year when there were no founderings or loss of vessels the mortality was 5·7/1,000.

Moore found much that was wrong with the medical care of trawlermen. Of 38 fishermen 18 were not registered with a general practitioner. The skippers' and mates' certificates of competence in first aid may have been taken years previously; skippers complained of difficulty in understanding their book of medical guidance and preferred to contact the naval protection vessel. He estimated that when there were full patrols 15 to 20 fishermen a month would receive care from this source, but the squadron has now been withdrawn. Logging of injuries and disease was incomplete and often inaccurate—"contusion" was used to describe extensive and severe soft tissue injuries. Tragedies occurred; a mate died of peritonitis ashore, after three days' illness at sea. Unfit men returned to sea after attacks of coronary thrombosis, recurrent hernia, or renal calculi, and continued until they died or became permanently disabled.

Moore has made some important recommendations. New legislation is needed, accidents causing injury or death should be made notifiable and be properly recorded and investigated, and an inspectorate with the same powers as under the Factory, Mines and Quarries and Agriculture Acts should be established. The trawler owners should employ safety officers to investigate accidents and advise on safety. Courses in accident prevention should be arranged and attended by fishermen as part of their duties. More attention should be paid to safety devices in ships, and adequate handrails and safety lines should be installed; warps, winches, and other dangerous machinery should have guards. Better protective clothing should be provided.

There is also a need for an occupational health service for fishermen. Pre-employment and periodic medical examinations should be compulsory, and trawler owners should cooperate by refusing passages to men certified as unfit.

[1] Moore, S. R. W., *Brit. J. industr. Med.*, 1969, 26, 1.
[2] Moore, S. R. W., *Brit. J. industr. Med.*, 1969, 26, 25.