Training Anaesthetists

SIR,—I should like to add the following comments to those already expressed in your leading article on training of anaesthetists (22 January, p. 194) and in the correspondence that followed (5 February, p. 372).

Clearly the authors of *Proposals for the Future Training of Anaesthetists*[1] and of *Higher Specialist Training for Anaesthetists*[2] have not felt it within their terms of reference to discuss the related problems of manpower and recruitment. However, the recommendations that anaesthetists should as part of their training obtain experience in medical posts such as general practice or general medicine indicates that these plans are likely to prove expensive in terms of manpower. I would suggest that unless the traditional structure of anaesthetic staffing in hospitals is considerably modified the proposed schemes will have to be restricted to centres where resources are relatively plentiful and that, despite the declared intention to implement training schemes flexibly, a proliferation of section 38 non-teaching service posts is inevitable.

An even distribution of staffing allied to training schemes could be achieved if junior doctors from certain specialties were encouraged to undergo a preliminary one year's training in anaesthetics by ensuring that such a course seemed relevant to their future career. A body of partially-trained but certificated anaesthetic personnel would thus be created who could provide a supplementary anaesthetic service in such spheres as anaesthesia for E.C.T., extradural analgesia in obstetrics, minor accident surgery, and dentistry and resuscitation in coronary care, intensive therapy, and neonatal emergencies. The specialties who seconded their staff for this training would then become self-sufficient for a proportion of their anaesthetic requirements. The first and second year of general professional training would seem suitable for accommodating this scheme.

If the above course was followed not only would adequate and predictable staffing of junior anaesthetic posts become possible but anaesthetic consultants would find greater satisfaction in their work as their duties embraced the teaching and consultative work implicit in such changes.—I am, etc.,

C. J. R. ELLIOTT

Welwyn Garden City,
Herts

1 Faculty of Anaesthetists of the Royal College of Surgeons of England, *Proposals for the Future Training of Anaesthetists*. London, Revised 1972.
2 Joint Committee for Higher Training of Anaesthetists at the Royal College of Surgeons of England, *Higher Specialist Training*. London, 1972.

Medical Advice on Contraception

SIR,—It is often implied in the press, sometimes even in the medical press, that any sort of restraint in prescribing "the pill" is always the result of religious or moral prejudice. It is refreshing, therefore, to read Dr. Violet Anderson's "Personal View" (26 August, p. 524).

Advice on true "family" planning—that is, on the spacing and limitation of children in the family—is relatively simple. But, to advise those who seek coital experience without its normal biological consequences outside any concept of family is more difficult. As Dr. Anderson says, a girl of 16 or 17 may have to subject herself to six or seven years of physiological manipulation. Her chances of being involved in emotionally disturbing and biologically frustrated relationships must be increased—and this before her "family planning" even begins.

It has been said that a woman's sexual experience is not complete until her child is weaned, while the long-term effects on the individual, let alone those on the community, cannot yet be predicted. To describe all this as "natural behaviour" is clearly false. In short, the unwanted pregnancy is not the only problem on which advice and education is needed.

My experience in general practice is that engaged and married couples earnestly seek and are grateful for advice. Some of the others, however, just want a prescription for the pill, have already determined their attitudes, and are not really interested in advice. They are also ignorant of basic biology, let alone their own physiology. With the environment putting so much stress on sexual arousal they are confused about means and ends.

Of course it is right that doctors should not primarily be concerned to approve or to disapprove, and that advice should be freely available. It usually is in general practice. And while advice is not always heeded any suggestion that all girls are morons, incapable of education, and in urgent need of birth control protection must be refuted. I support Dr. Anderson in believing that the medical profession must resist all pressures to prescribe without education, explanation, and advice.—I am, etc.,

E. O. EVANS

Stratford-upon-Avon

SIR,—Sex is for delight. Yes, but how delightful is sex outside the context of a loving relationship? How delightful is it to give oneself sexually without giving oneself in a much deeper sense? If sex is indulged at a superficial level can it become mechanical and debased? Has anybody done any studies?

Mr. Keith Norcross (9 September, p. 640) is compassionate about the impotent middle-aged man, but unfortunately shows no such compassion towards the wife who has "failed" and is to be replaced by the sex-therapist.—I am, etc.,

DEREK PHILLIPS

Huddersfield

SIR,—I feel compelled to protest at the inclusion of the "Personal View" article by Mr. Keith Norcross (9 September, p. 640). The content of "Personal View" is, usually, an informative and often entertaining comment on the less clinical aspects of medical practice. Mr. Norcross, with his advocacy of fornication, adultery, and sex-therapists, takes us beyond the fringe of generally accepted medical ethics into a world of licence with no definable code of sexual conduct. Surely the therapies suggested can be seen historically to have led to the general moral breakdown of societies if not nations.

If the author of this article were to return to the source material of true Christian sexual morality, as found in the *New Testament*, he would find to his dismay that Christ was not, in fact, a protagonist of "dishonesty, frustration, waste, guilt, misery, cruelty, blasphemy, and moral inversion."

Having qualified in 1968, I do not consider myself old but do feel that dissemination of such ideas as are expressed in this recent article would, when taken to their logical conclusion, tend to lead to depravity.—I am, etc.,

D. R. AYLIN

Sutton Coldfield,
Warwicks

SIR,—I do not believe that personal views on morality should influence our practice of medicine. Dr. L. H. Cane's letter (9 September, p. 647) suggests that he would not agree. Because there are medical factors involved in taking the contraceptive pill it is necessary for doctors to prescribe it. We were not, however, required to prescribe the pill in order to decide who should or should not take it on moral grounds.

I believe it is wrong for us to consider factors other than medical ones. That there may be moral issues also, I accept. The moral issues, however, should be discussed and decided outside the surgery by the individual concerned. It is an abuse of our professional position to attempt to impose our personal views on a captive audience.—I am, etc.,

J. A. LUNN

Northwick Park Hospital,
Harrow

Abdominal Distension

SIR,—On two occasions recently we have been concerned about persistent or recurrent intestinal distension after laparotomy and uncontrolled by conservative measures. Both patients were thought incapable of tolerating further surgery. It was therefore decided to adopt a veterinary procedure used for "blown" sheep and attempt percutaneous decompression using a trocar and cannula to insert a soft plastic tube.

In one case immediate and in the other slower but steady relief was obtained and recovery followed in both, the tube being removed after a few days. I have been unable to find a reference to this procedure in the human patient, doubtless owing to the inadequacy of the search, and I would be interested to hear of the experience of others.—I am, etc.,

G. A. D. LAVY

Pembury Hospital,
Pembury, Kent

Mechanics of Elastic Bandaging

SIR,—When an elastic bandage is applied to a leg for varicose veins or ulcer the object may be to empty the superficial veins of blood, but surely it would not be wished to interfere with the arterial supply or the microcirculation. I would suggest, therefore, that the pressure applied should not on any account exceed the pressure at the venous ends of capillaries. This varies, of course, from vessel to vessel and from time to time, and much more according to whether the patient is upright or recumbent. While not fearing that excessive compression is often applied to the legs of ambulent patients, I