million parts of salt, and within two years from the date of an Order all other prepacked salt should be similarly treated.

(ii) *Packaging:* To minimize loss of iodine, iodized salt should be packed in containers resistant to the effects of humidity changes. Packages containing iodized salt should be date-stamped before they leave the manufacturer.

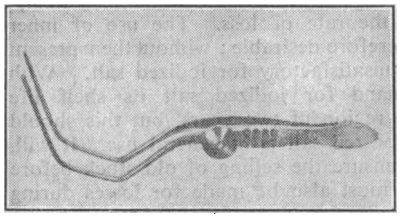
Answering these recommendations in the House of Commons on March 22, the Minister of Food, Mr. Webb, said that the recommendation of the Food Standards Committee would not take effect until June 30, to allow time for any representations to be made to the Committee by the public, the trade, and the medical profession.

Those wishing to make representations should write to Mr. K. R. Allen, Secretary of the Food Standards Committee, at the Offices of the Ministry of Food, Food Standards and Labelling Division, 47, Portman Square, London, W.1.

Preparations and Appliances

A NEW CLAMP FOR PORTOCAVAL ANASTOMOSIS

Mr. FRANCIS E. STOCK, F.R.C.S., professor of surgery, University of Hong Kong, writes: The operation of portocaval anastomosis has been carried out in this clinic on nine occasions through a transthoracic approach after removal of the tenth rib. A direct end-to-side anastomosis is made of the portal vein to the vena cava after division of the portal vein. One of the difficulties of the operation is in controlling the blood flow through the vena cava during the 10 to 15 minutes from the time of ligation and division of the portal vein to the completion of the anastomosis. If the vena cava is completely occluded, as was done in the early cases in the series, the blood pressure falls very considerably during the period of occlusion. V. P. Satinsky (*Ann. Surg.*, 1948, **128**, 938) has suggested the use of a Stille kidney clamp to occlude the vena cava partially, but this instrument has seemed to be too clumsy, although a similar clamp was used on several occasions. A small light clamp which would grip the vessel firmly, leave two-thirds of the caval lumen open, and be out of the way of the surgeon's hands seemed to be desirable.



Such a clamp has now been made for me in the engineering workshops of the University of Hong Kong. It is small and light, and can be applied by thumb pressure and fixed in place by a milled nut. The inner surfaces of the blades have a single longitudinal groove which prevents slipping from the vein and yet does not traumatize the vein wall. The clamp has no rubber tubing on the blades. It has been used on the last three cases with complete success. At least two-thirds of the vena cava lumen remains patent through the period of the anastomosis, and the systemic blood pressure does not fall.

Shorter training and a wider field for recruitment are features of altered conditions for the National Hospital Service Reserve in England and Wales announced by the Ministry of Health. Part-time hospital nursing staff, and non-nursing staff, either whole-time or part-time, can now join the Reserve. The only exception is hospital domestic staff. Previously, neither nursing nor non-nursing staff in hospitals or similar institutions could join. Hospital training for nursing auxiliaries has been reduced to 48 hours in six days (whole-time) or 80 hours in nine months (part-time). Compensation to auxiliaries for loss of earning during their hospital training will now be payable whether it is whole-time or part-time provided the period of training is four hours or more. Up to the end of January over 1,800 trained nurses and nursing auxiliaries had joined the Reserve.

Correspondence

Intrathoracic Goitre

SIR,—I abate not one whit of my admiration for the literary erudition and surgical skill of Mr. Geoffrey Keynes as evidenced in his Legg Memorial Lecture (March 18, p. 621), but there are one or two statements which provoke a reply. When discussing the difficult problem set by intrathoracic goitre, he states: "There is always danger lurking in the acquirement of fixed habits of mind. Thus a thoracic surgeon who assumes that all intrathoracic tumours can be suitably removed through a transpleural approach may be for a few moments dismayed. . . . He must then hurriedly try to recollect what he once knew years before about the anatomy of the neck. . . ."

I trust that the average thoracic surgeon would not be so mentally and technically unprepared. Though sometimes regarded as a "specialist" in the derogatory sense of the term, the chest surgeon can claim by training and his practice to be a truly "general" surgeon working over a limited anatomical field. Intrathoracic goitres are fairly commonly met with in thoracic surgery, and in the differential diagnosis of any rounded tumour close to the mediastinum the possibility of abnormally placed thyroid tissue should always be considered. Indeed, some forms of intrathoracic goitre have little or no demonstrable connexion with the neck, and their nature is only finally determined by pathological investigation (the "mediastinal aberrant goitre" of Rives).

Most cases of retrosternal goitre can be removed through the standard neck incision, but, as Mr. Keynes has pointed out, a few cases require splitting of the sternum, which increases the exposure and converts a "blind" into an "open" operation. Whether this is preferable to a transpleural approach in the case of posterior mediastinal tumours is debatable.—I am, etc.,

London, W.1. T. HOLMES SELLORS.

Maternity and the N.H.S.

SIR,—My committee views with grave alarm the article published in your issue of February 18 (p. 392) entitled "Maternity and the National Health Service." Before the Health Service started the B.M.A. issued a statement of the "Fundamental Principles of the Medical Profession in connexion with the National Health Service," of which the second and third are pertinent to the discussion.

2. "The medical profession should remain free to exercise the art and science of medicine according to its traditions, standards, and knowledge, the individual doctor retaining full responsibility for the care of the patient, and freedom of judgment, action, speech, and publication, without interference in his professional work."

3. "The citizen should be free to choose or change his or her family doctor, to choose, in consultation with his family doctor, the hospital at which he should be treated, and free to decide whether he avails himself of the public service or obtains independently the medical service he needs."

The committee is very much concerned that a distinguished member of the profession should go so far in his article as to state that his professional brethren are less capable of conducting normal maternity cases than a midwife, and by so doing deny these freedoms to doctor and patient alike, and at the same time gravely prejudicing the harmony that should exist between midwife and general practitioner throughout the country.

The writer of the article states, "The administrative arrangements necessary to regulate the general practitioner's part in the maternity service present considerable difficulty," and, further, "It would be unfortunate if in a matter which is confessedly difficult and even delicate we should, through lack of the spirit of conciliation and statesmanship, fail in our effort to reach the aim accepted by us all as the ultimate desideratum—the unbroken continuity and singleness of control of the

woman throughout the whole of her time of pregnancy, labour, and puerperium."

We fail entirely to see any sense of conciliation or statesmanship in the article that is before us where it concerns general practitioners, who incidentally far outnumber the specialists and probably conduct far more maternity cases. It appears to us, representing the 1,550 general practitioners in Middlesex, that the ultimate aim of us all, to help the patient in the best way possible, is ill served by one section of the profession decrying the capabilities of another section.—I am, etc.,

London, W.C.1. R. L. RIDGE,
Chairman, Middlesex Local Medical Committee.

SIR,—Your issue of February 18 contains much food for thought for those interested in obstetric practice in this country. Professor James Young (p. 392) does a great service in pleading with such vigour for an integration of purpose and effort. Not everybody will agree, however, with his lavish idolizing of midwives. To my mind it does not make sense to talk of "degrading the midwife to the status of a maternity nurse," because after all a midwife is a nurse and not some strange hybrid on a different plane. The late Joseph de Lee, who is recognized as one of the greatest obstetricians this world has seen, stated quite emphatically that "every labour should have two physicians if possible."[1] This, of course, is an ideal which cannot be realized in this country at the moment except in a very few favoured cases. It is very important, however, not to reject an ideal simply because it cannot be fulfilled.

Of course those people who maintain that normal midwifery is the special province of midwives, and should remain so for all time, are the victims of faulty reasoning. Parturition, they say, is a "natural" process; therefore leave it to "nature" and all will be well. It were as if "nature" were an all-wise, perfect, and sufficient demigod. The truth of the matter is that to sustain a compound fracture of the femur, to develop peritonitis, and to have one's shoulder blown off in battle are also natural events in that they occur with great frequency in the realm of nature. Truly nature, as opposed to an individual's idealized concept of nature, is most imperfect and very often is quite cruel. Parturition is a process which very often goes wrong and very often manifests the imperfection of nature. The attitude of mind of the obstetrician therefore should not be one of adoring passivity but should be akin to that of a general in command of an army in the field. The good obstetrician has to be a master of a strategy of a special sort and able to perfect imperfect parturition by the successful imposition of his will; and in making this assertion the last thing I have in mind, needless to say, is the "meddlesome midwifery which has cost thousands of valuable lives."[2] The perfection of parturition which I have referred to can be accomplished only by one who has had a full medical training.

Another important point to notice is this. While it is true to maintain that a high maternal and foetal mortality rate points to bad midwifery, the converse is not necessarily true. Good obstetric practice entails more than low mortality and morbidity rates. I myself know two large maternity hospitals where the mortality rates are very low but where I cannot describe the practice of midwifery as excellent. As I see it, it is mainly because British obstetricians have thought too exclusively in terms of mortality rates that their plans for a national maternity service have not met wider acceptance. Their plans have been good so far as they went, but they have never gone far enough. The supercilious attitude adopted by many obstetricians to the subject of analgesia in childbirth is just one example of the frame of mind to which I am trying to draw attention. Even on reading Professor Young's paper one feels that he is far more concerned with "the status of the midwife" than with the comfort of his parturients.

It is disappointing to see so much criticism, to a large extent by innuendo, of general practitioners in Professor Young's paper. As one who has seen a good cross-section of midwifery in this country I can confidently affirm that neither section of our profession is in a position to throw stones at the other.

Finally, in the same issue of the *Journal*, Professor Alexander Kennedy deals with some very important matters in his paper entitled "The Psychology of the Surgical Patient" (p. 396). It is my considered opinion that obstetrics will gain enormously when a similar study is made of the psychology of the obstetric patient.—I am, etc.,

JAMES ROSS.

REFERENCES

[1] *Principles and Practice of Obstetrics*, 1943, Philadelphia, p. 243.
[2] Ibid., p. 267.

SIR,—A further article on the maternity service by Dr. D. W. James has now appeared in your *Journal* (March 11, p. 598), which, following on that of Professor James Young (February 18, p. 392), shows only too clearly the policy of our senior colleagues in this particular branch of medicine. Having shown that the greatest single advance in the reduction of maternal mortality was the discovery and use of chemotherapeutic agents, he concludes his article by saying, "If there is an increase in mortality [maternal] then general-practitioner midwifery is finished for all time." Why is the G.P. selected as the scapegoat for any possible future rise in the maternal mortality rate when it is clear that two other persons are equally involved—e.g., the midwife and the specialist? To quote examples of bad G.P.s is as useless as it is odious, and it would not be difficult for G.P.s to retaliate in kind. Surely, if it is thought that the G.P. is not fit to undertake midwifery, this is a matter for a searching examination of our present teaching. To make a man pursue a certain prescribed course, sit and pass an examination, and finally give him a licence to practise, then to withhold that right on the grounds that he has no special knowledge is nothing short of chicanery.

But I am concerned with much wider issues. What is happening in obstetrics to-day can be happening in, say, children's diseases to-morrow. Pushed to its logical conclusion, the newly qualified doctor could find himself precluded from practising any branch of medicine for the reason that he has no special experience. The fear that this may happen is only increased when one considers the alarming growth of quasi-specialties and their concomitant diplomas (e.g., D.C.H., D.A., etc.) which has taken place in the last few years. The role of general practitioner sorting-clerk looms amazingly near, and is not such a figment of the imagination as many would have us think. Something must be done to stop this dismemberment of the general practitioner.

It is pertinent to note that these articles, which so closely affect the G.P.'s future, are not ministerial in origin. We are gradually being degraded by our own colleagues, those in high places who have access to the official ear. (This probably throws some light on the amazing debacle of the profession after the second plebiscite.) It is now up to these same colleagues to see that this policy is reversed and that the general practitioner gets a square deal.—I am, etc.,

High Wycombe. W. YOUNG.

SIR,—The reflections upon the emergency maternity service by Dr. D. W. James (*Journal*, March 11, p. 598) are so startling that they might have come from the pen of Dr. Cronin. Who will champion the cause of the general practitioner? Nay, shortly, who will become a general practitioner—apparently the most incompetent member of the profession?—I am, etc.,

Glasgow. J. E. KENNEDY.

An Appendicular Faecolith

SIR,—Mr. Eric Coldrey (March 18, p. 673) is quite right when he says that appendix concretions opaque to *x* rays have received scant recognition in the standard textbooks. I came across a striking example of this condition some years ago and published a brief note in the *Journal* (December 20, 1930, p. 1041). If Mr. Coldrey turns it up he will find a number of references to the literature on the subject. In the *Journal* of July 27, 1907 (p. 199), Dr. O. T. Williams, of Liverpool, wrote an account of the growth of the calculi *in situ* by a process of saponification.—I am, etc.,

Liverpool. CHARLES WELLS.