Correspondence

Maternity and the N.H.S.

SIR,—I cannot reply to all the criticisms of my article on "Maternity and the National Health Service" (February 18, p. 392). In regard to the urgent need for co-ordination of the maternity functions of the local authorities, boards, and executive councils I greatly value the support of Dr. C. Tangye and Mr. K. Vartan (March 11, p. 605). Dr. Tangye speaks with the authority derived from long experience as an administrator and as a member of the departmental committee on maternal morbidity and mortality. Mr. Vartan points to methods for reaching some measure of local co-ordination, but he would doubtless agree that, helpful as it is, such loose and friendly accommodation between the agencies concerned must inevitably fall short of that compact administrative fusion of interests which is essential for unitary control.

This co-ordination is as much in the interests of the G.P. as it is imperative for the security of mother and child. For continuity of supervision is possible only when midwife, doctor, and clinic and hospital officers are linked as a team. This in its turn can function effectively only if the doctor has access to the hospital and clinic. Otherwise his midwifery is robbed of its interest and he finds himself in a backwater in which he becomes more and more stranded as the years go by. He can help materially in the medical care of his patients but he cannot become an obstetrician.

It is my firm conviction that a maternity service which accepts the G.P. as an integral member of its staff must incorporate these principles in its evolution. This ideal can be reached only by the doctor realizing that it is not a man's job to undertake the midwifery that happens to come his way in a general practice of 2,000. With a birth rate of 17 per 1,000 this means 34 deliveries a year, half of whom go to hospital. With this quota, and a forceps rate of 4%, the doctor will be called upon to use his instruments four times in six years. Can he become or remain experienced at this rate? If he is to derive the satisfaction that alone comes from sound work he must, after his special training, seek wider opportunities for the practice of his art. It is here that the grouping of practices will play an essential part.—I am, etc.,

London, W.12. JAMES YOUNG.

Acute Perforated Peptic Ulcer

SIR,—Since the publication of our paper[1] on the fall in mortality of acute perforated peptic ulcer, the figures for 1949 have been carefully analysed and show a further fall in operative mortality. The following figures are taken from Table III in the original paper, with the addition of the 1949 results.

	1945	1946	1947	1948	1949
Total Cases	45	53	58	57	69
Total Deaths	9	10	8	3	5
Unoperated cases					
Number	4	7	6	3	5
Deaths	4	7	5	2	5
Operated cases					
Number	41	46	52	54	64
Deaths	5	3	3	1	0

It will be observed that during 1948 and 1949 there was only one death among 118 operated cases. The five cases not operated on, who died, were as follows:

M. 64 (D.U.) ..	3-day perforation ..	Peripheral circulatory failure not responding to treatment.
M. 64 (D.U.) ..	3-day perforation ..	,, ,,
M. 72 (D.U.) ..	15-hour perforation ..	,, ,,
M. 63 (G.U.) ..	2-day perforation ..	,, ,,
M. 80 (D.U.) ..	Diagnosed as coronary thrombosis; previous anginal pain.	,, ,,

The very low operative mortality which can be achieved sets a difficult target for those who believe in the medical management of acute perforations. Gill and Jenkins's[2] series of conservatively treated duodenal ulcers is, unfortunately, still too small for a final comparison with our series. However, they can reasonably omit their first four deaths, as they were patients whose peripheral circulatory failure did not respond and who would not have been operated on even if a surgical bias had existed. Although we advocate a surgical policy we hope that their series will be continued.

We have been very conscious of our debt to our anaesthetic colleagues, but, unlike Dr. R. Mailer,[3] we cannot demonstrate that the big fall in mortality occurred before the introduction of sulphonamide therapy. Our series had the advantage of having an easy and uniform availability of senior anaesthetists throughout the period recorded. We feel that modern anaesthetic techniques have appreciably contributed to the successful results, but to a lesser extent than antibiotics.

I am grateful to Dr. George Graham[4] for reminding me that I had not mentioned the post-operative administration of ascorbic acid. This has been a routine, and the recommended dose is 200 mg. three times a day for five days.—I am, etc.,

London, N.W.10. F. AVERY JONES.

REFERENCES

1 Jones, F. Avery, Parsons, P. J., and White, B., *British Medical Journal*, 1950, 1, 211.
2 Gill, W. G., and Jenkins, T. P. N., ibid., 1950, 1, 488.
3 Mailer, R., ibid., 1950, 1, 372.
4 Personal communication.

The G.P. at the Crossroads

SIR,—Having carefully read the report on general practice in England to-day by Dr. J. S. Collings in the *Lancet* (March 25, p. 555) and having discussed it with many colleagues, especially in general practice, I feel compelled to criticize your leading article on this report in the *Journal* of the same date (p. 709). Indeed, I find, as Dr. Collings said on other matters, that I am "unable to correlate the thoughtful opinions of the majority with the statements of the organization which represents them."

I can only fully agree with your opening remarks that the most important problem of modern medicine is the status of the general practitioner. The compilation of this report led Dr. Collings not only to recognize the importance of general practice but also the "danger of continuing to pretend that it is something which it is not." Whether Dr. Collings's report is a true reflection of the whole of general practice is not a point which can be answered by reference to the general health of the people to-day. What is of importance is whether or not general practice is playing its full part with the many other factors, including other aspects of the medical service, which contribute to the level of the health of the people. If this report only emphasizes the worst aspect of general practice then it is still the duty of those who have the dignity and high reputation of our profession at heart to consider it closely. We should indeed be indebted to Dr. Collings for focusing our attention upon this vital problem.

To this end I find your criticism unworthy. I do not see, for instance, how you could pen the sentence, "He really seems most reluctant to find a good word to say for those who patiently subjected themselves to his scrutiny," when Dr. Collings is at great pains not to defame the "overworked and often conscientious doctor who has to suffer the indignities of this way of working." It is also difficult to see how you avoid dealing with the particularly constructive reference to the importance of group practice and health centres.

You say that this report "will focus the medical spotlight on to general practice," yet it seems to me that your leading article, in trying to minimize the importance of the report, can only have the opposite effect. Your remark, "It is much to be hoped that some organization will now set on foot a systematic investigation into the condition of general practice. . . ." cannot be regarded as a call to action by any stretch of the imagination. Yet Dr. Collings calls first for an investigation by those most concerned—namely, "ordinary" general practitioners, with their "breadth of vision" and "latent enthusiasm," who have such a "valuable contribution to make in the whole field of thought on medical care."

It seems to me that we should approach the report in a much more constructive manner, and to this end I would like to make some practical suggestions: (1) that this report be reprinted and