venereal disease, demand for abortions, or of battered babies?

Of course there is need for agencies where birth control facilities can be obtained. The disadvantage of the "slot machine" provision of contraceptives or the old "buy me and stop one" principle is that they may prevent from seeking advice the very people who need it most. The real tragedies are due to ignorance, insecurity and the results of permissiveness, whether fashionable or not. The great need is for more opportunities for mature counselling, and for responsible parenthood.

We need far more experiments in how to provide services and support for those who are most in need; more health visitors and auxiliaries to identify families at risk before the baby is battered; and more experiments in how to train doctors and nurses who can provide these services.—I am, etc.,

CICELY D. WILLIAMS.

London, S.E.24.

Clinical Research in District Hospitals

SIR,—We live in an age when the drama of transplantation techniques and its associated multidisciplinary team work has caught the imagination of the news media and the public that they serve. Many doctors, including a number responsible for advising young doctors about research projects, also appear to have succumbed to the fascination of expensive projects and their associated gadgetry. While realizing the value of this type of research, we still consider clinical research, which teaches the doctor to assess individuals as well as statistics, to be equally important. This is particularly true in developing countries where students and doctors still have to depend, in the main, upon textbooks that follow the European and American pattern of disease and its treatment, which may give a very inappropriate view of medical practice for the medical worker living in the less wealthy parts of the world.

We were, therefore, greatly encouraged when we read Dr. W. F. Whimster's personal view (25 April, p. 233) about the value of recording local disease patterns. For we too are clinical research "addicts" and have the good fortune to work in a district hospital with a 15-year tradition of finding out. This has resulted in over 50 papers about local medical needs, some of which have influenced medical practice far outside the borders of Nigeria. We are in no doubt that the extra work entailed has added to our own job satisfaction, to the interest of junior staff and visiting students, and to the health of our patients. Unfortunately it is not always so easy to convince charitable organizations and research foundations about the value of this type of research, particularly when it is not a university project.

We believe that data from district hospitals are of especial value, for these are the institutions giving a comprehensive medical service to the surrounding population with none of the patient selection that is necessary in a teaching hospital. An added advantage of the district hospital view is that the practical answers that we seek to find must, of necessity, be simpler, less expensive, and therefore more applicable to

the majority of medical workers in a developing country than the answers emanating from a well-staffed and well-equipped teaching hospital. Despite this, all too often philanthropic organizations will provide expensive equipment or buildings for research, but find it difficult, for example, to give the few hundred pounds necessary to employ a full time clerk to help in searching for records and analysing punch cards. We have both learned much from personally searching for record cards, and we dare to think that our filing and records systems have improved as a result. However, we could do much more as doctors if we didn't have to be clerks as well. Perhaps it is not always realized that trained staff, money, materials, and time are so desperately short in the average district hospital.

We therefore hope that not only will Dr. Whimster's viewpoint stimulate doctors in the field to learn from the vast amount of clinical material that they see, but also will alert sponsoring organizations to the value of basic clinical research performed in district hospitals. There must be many other small provincial voices who, like us, would appreciate and benefit from a new look at research support procedure and priorities.—We are, etc.,

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T. O. MULLIGAN.

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Ilesha, Nigeria.

Maternal Deaths

SIR,—I have read with very great interest your leading article on unnecessary deaths (23 May, p. 437). From which I quote: "Of the 579 reported maternal deaths, 50 . . . were classified as having avoidable factors . . . Most of the avoidable deaths were caused by inhalation of stomach contents."

In 1925 I started using general anaesthesia (open chloroform) in my obstetric practice. All the anaesthetics have been administered in the left lateral position, and I cannot recall having any serious anaesthetic complications. I have found that the prohibition of solid food during the accouchement practically impossible to obtain in domiciliary midwifery.

As the trend is for more hospitalization of maternity cases the danger is that there will be an increase in the number of avoidable deaths unless there are some drastic changes in the administration of anaesthetics.—I am, etc.,

Sheffield, Yorks.

J. G. COONEY.

SIR,—In your leading article (23 May, p. 437) attention is very properly drawn to the disturbing increase in maternal deaths associated with anaesthesia, as shown by the most recent *Report on Confidential Enquiries into Maternal Deaths*.¹

With almost monotonous regularity all five of the triennial reports have demonstrated that well over half the fatalities have been due to inhalation of stomach contents. In the report covering the period 1958-60 there are two statements of particular significance. I quote:

(1) The only safe assumption in any

parturient woman is that the stomach is full.

(2) The lithotomy position with full flexion of the lower limbs is more likely to favour regurgitation than any other posture.

Few anaesthetists of any experience in obstetric anaesthesia would question the validity of these pronouncements. Indeed many would agree that the disastrous consequences of adopting this strange fashion in forceps deliveries could have been foreseen. The gravest of calamities in obstetric anaesthesia (inhalation of vomit) simply does not occur if the lateral position is used.

For the last 15 years I have from time to time invited anyone to produce a record of even a single death from inhalation of vomit when the lateral position has been used.² There has never been a response to my challenge. On the other hand I have drawn attention to a series of deaths in several places from aspiration of vomit where the lithotomy position has been used.³ It is in fact just about as stupid and unnecessary to use the lithotomy position in forceps delivery as it would be to use it for a comatose patient with a head injury in order to do a rectal examination.

I feel certain that anaesthetists in general are fully aware of the dangers involved, but it is by no means clear that obstetricians (who after all call the tune) are even reasonably aware of the risks inherent in the continued use of the lithotomy position.

Spinal analgesia for caesarean section is clearly causing concern, and in this connexion Mr. L. Courtney in his most interesting memorandum on the supine hypotension syndrome (28 March, p. 797) points out the need for the urgent and effective treatment of the condition by turning the patient on her side. This point is stressed also by Mr. R. W. Beard and Miss Gillian M. Roberts (2 May, p. 297).

If, as a routine procedure during general anaesthesia for caesarean section, induction and intubation are carried out with the patient in the lateral position, the risks of inhalation of vomit must be greatly diminished, especially in emergency lower segment caesarean section. It is here that the expert anaesthetist is so vitally needed.—I am, etc.,

A. H. MORLEY.

London N.W.7.

REFERENCES

- 1 Arthure, H., et al., *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1964-66*. London, H.M.S.O., 1968.
- 2 Morley, A. H., *British Medical Journal*, 1955, 2, 1351.
- 3 Morley, A. H., *British Medical Journal*, 1954, 2, 299.

G.M.C. Elections

SIR,—At the end of March I wrote a letter to you about the approved procedure for selecting the official B.M.A. candidates for election to the General Medical Council in 1971. These candidates are to be chosen by the Annual Representative Meeting (1970) from names submitted by Divisions. Their election addresses will be sent to all registered medical practitioners in the countries where election is contested. This will be done at the Association's expense and cannot cost less than £1,000 if there is a contest in England and Wales. I do not suppose any independent candidate will be able