

Until the health authorities (and their advisors) recognise that most general surgical consultant posts can be filled by the non-specialist the needs of the general surgical trainee will continue to demand a specialist training so that the individual can continue to compete for the increasingly limited number of consultant vacancies.

T C B DEHN
HUGH BISHOP
ALAN BERRY
K I BICKERSTAFF

John Radcliffe Hospital,
Oxford OX3 9DU

1 Dehn TCB, Blacklay PF, Taylor GW. A survey of registrars undertaking general surgical research in the United Kingdom on 1 October 1983. *Br J Surg* 1985;72:668-71.

SIR,—One of the reasons why we should not see the demise of the old fashioned general surgeon has been missed by all your correspondents (5 April, p 955), and that is geography. There are a number of us who, working in remote areas of the UK, give a general surgical service in the true sense of the term, looking after patients with ingrowing toenails, colonic carcinomas, peptic ulcers, gall stones, bladder neck obstructions, and renal carcinomas with a bit of orthopaedics and trauma thrown in for good measure.

Much as this might horrify some of your readers, especially those who believe that no civilised life exists north of Watford and no life whatsoever exists north of Inverness, surely the answer must be that a general surgeon should continue to treat conditions that he feels competent and happy to deal with. Up here if all urology had to be dealt with by urologists (and by that I do not mean general surgeons with an interest in urology) and vascular surgery by a wholtime vascular surgeon, these patients would need to make a round trip of some 460 miles; similarly, if all orthopaedics had to be dealt with only by orthopaedic surgeons that would entail a round trip of about 250 miles. Before readers rush to their world maps to see where in darkest Africa this place is, I hasten to add that it is in mainland Britain.

Even in less remote areas the need for a general surgeon (albeit with a special interest) will, I believe, continue for the simple reason of economics. For example, if all benign prostatic hypertrophies were to be done transurethrally by urologists (and there is no doubt that would be ideal) urologists would be snowed under with mundane urology which could easily be carried out by general surgeons, admittedly sometimes through a less than ideal approach—the open prostatectomy. The time factor (and thus economics) is another reason: it should take a general surgeon (of registrar grade) less time to remove an 80 g benign prostatic adenoma retropublically than a urologist to remove it transurethrally. We should reserve the help of our specialist colleagues for the really difficult case, which is usually more a problem of opinion than technical skill.

When it comes to emergency vascular surgery, such as a condition that threatens life (ruptured abdominal aortic aneurysm) or limb (arterial embolus), often in a district general hospital, and certainly in remote areas, surgery has to be carried out by a general surgeon. Ironically, an elective abdominal aortic aneurysm is always operated on, and very rightly so, by a vascular surgeon or one with an interest. Once again, for every vascular emergency in the UK to be treated by a vascular surgeon would not be feasible.

One reason why we should continue to have general surgeons is well explained by Bewes in a recent article on head injuries. He states that specialisation in the UK might have reached such a state that “in some overseas mission hospitals with

very limited facilities the provision of head injury care for rapidly deteriorating cases may be better than in some parts of the UK.”¹

Geography and economics coupled with common sense will ultimately make sure that the days of the general surgeon are not numbered in the UK.

PRADIP K DATTA

Bignold Hospital,
Wick, Caithness,
Scotland

1 Bewes PC. Head Injuries: whither specialisation? *J R Soc Med* 1986;79:67-8.

Fetal monitoring in labour

SIR,—Mr D D Mathews (22 March, p 826) believes that the method of intermittent auscultation of the fetal heart which he uses is superior to the method evaluated in the Dublin randomised trial. We have also heard that other obstetricians believe that their methods of interpreting fetal heart rate traces are superior to those evaluated in the trial. These beliefs should be seen for what they are: clinical opinions which cannot (so far) be supported with evidence from properly controlled clinical experiments.

Dr Mathews has already tested the validity of a number of his beliefs in other areas of obstetric practice by mounting randomised trials.^{1,6} We hope that he and others who believe that more effective methods of intrapartum fetal monitoring exist than those compared in the Dublin trial will apply similar scientific self discipline in respect of these beliefs.

DERMOT McDONALD

National Maternity Hospital, Dublin

ADRIAN GRANT
IAIN CHALMERS

National Perinatal Epidemiology Unit, Oxford

- 1 Mathews DD, Friend JB, Michael CA. A double-blind trial of oral isoxuprine in the prevention of premature labour. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 1967;74:68-70.
- 2 Mathews DD, Loeffler FE. The effect of abdominal decompression on fetal oxygenation during pregnancy and early labour. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 1968;75:268-70.
- 3 Mathews DD, Hossain H, Bhargava S, D'Souza F. A randomised controlled trial of an oral solution of prostaglandin E2 and oral oxytocin used immediately after low amniotomy for induction of labour in the presence of a favourable cervix. *Curr Med Res Opin* 1976;4:233-40.
- 4 Mathews DD. A randomized controlled trial of bed rest and sedation or normal activity and non-sedation in the management of non-albuminuric hypertension in late pregnancy. *Br J Obstet Gynaecol* 1977;84:108-14.
- 5 Mathews DD, Agarwal V, Shuttleworth TP. The effect of rest and ambulation on plasma urea and urate levels in pregnant women with proteinuric hypertension. *Br J Obstet Gynaecol* 1980;87:1095-8.
- 6 Mathews DD, Agarwal V, Shuttleworth TP. A randomized controlled trial of complete bed rest versus ambulation in the management of proteinuric hypertension during pregnancy. *Br J Obstet Gynaecol* 1982;89:128-31.

Getting the balance right

SIR,—Recent correspondence has emphasised both the independence of the *Drug and Therapeutics Bulletin* and its role as being unashamedly consumer orientated and taking trouble to provide balancing as well as balanced information. It should be noted that its fellow traveller, the *Adverse Drug Reaction Bulletin*, while enjoying the same distribution facilities, does not always express its opinions with the same degree of independence from the pharmaceutical industry. Thus a recent article on drugs and fibrotic reactions (August 1985, No 113) was written from Imperial Chemical Industries, who manufacture β blockers. As a substantial section of the article dealt with the

possible relation of β blockers to retroperitoneal fibrosis and other fibrotic reactions it would have been more valuable to have obtained an assessment which was clearly independent of the drug industry.

D W BULLIMORE

St James's Hospital,
Leeds LS9 7TF

SIR,—We are sorry to have to take further space in your correspondence columns, but Dr Roy Goulding's letter (19 April, p 1080) cannot go unanswered, at least so far as his challenge to the independence and effectiveness of the *Drug and Therapeutics Bulletin* is concerned.

The *Bulletin* has been published by the Consumers' Association since 1963; the copyright is vested in the Consumers' Association, which appoints the editors and the editorial board. Other than prudent concern for legal aspects of publishing, the publishers do not interfere in the editorial process and they allow the editors editorial freedom.

The *Bulletin* is not “sponsored” by the Department of Health in any meaningful sense of the word. The Department of Health, the Welsh Office, the Central Services Agency in Belfast, and the General Medical Services Board in Dublin have all, at different times, asked us to quote for the supply of the *Bulletin* to doctors, which we have been glad to do. None of these agencies has at any time sought to influence the editorial policy of the *Bulletin*, as one of us (AH) made clear in an earlier letter (8 March, p 692).

In recent years we have carried out, using an independent market research agency, an annual readership survey of attitudes to the *Bulletin* among its recipients. Dr Goulding and your readers may be interested in the following highlights from the most recent survey: 95% of recipients scan or read all of each issue, 75% find something of interest in most issues, a high proportion of readers of specific individual articles find them useful, a majority refer to back numbers at least twice a year, and 45% find the *Bulletin* very useful in making prescribing decisions. A follow up survey of non-responders to the 1983 survey revealed comparable results to those from responders.

ANDREW HERXHEIMER

Editor

ANTHONY LAND

Head of publishing

Drug and Therapeutics Bulletin,
London WC2N 6DS

SIR,—We note with interest that Dr Andrew Herxheimer (12 April, p 1014) is happy to make use of a correspondence column when defending his article but denies that right to others.

N L BROWSE

K G BURNAND

**This correspondence is now closed.—ED, *BMJ*.

Correction

Analysis of authorship

We regret that part of a reference was omitted from this letter by Ms S M Mould (12 April, p 1017). The last reference (4) should have read: Alvarez-Dardet C, Gascón E, Mur P, Nolasco A. 10-year trends in the *Journal's* publications. *N Engl J Med* 1985;312:1521-2.