ourselves whether we are not taking yet another step in the direction of the partial dissolution of the family? And might not some of our contemporary social problems be a result of this tendency?—I am, etc.,

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Training of Surgeons

SIR,—Mr. Neville Stidolph's article on the training of surgeons (9 November, p. 379) and his timely recommendations will I hope be implemented with a sense of urgency which has so far been lacking in previous attempts to reform surgical training.

May I comment on two points? Firstly, although one cannot dispute Mr. Stidolph's figure that only 12% of aspirants pass the English Fellowship, my impression is that a much higher proportion of my friends and acquaintances who seriously set out to become surgeons have eventually gained the F.R.C.S. This, of course, only serves to compound the disappointment and frustrations which are rife in the large group of fourth- and fifth-year registrars. Probably, in order to calculate an accurate figure for the Fellowship pass rate, it would be necessary to analyse by name the numbers of candidates sitting for the primary and final examinations over a five-year period.

Secondly, the training scheme proposals appear to make no allowance for the post-registration doctor who wishes to step out of line for one or two years for such commendable reasons as foreign travel or to gain a wider experience of life and living. There is much to be said in favour of a prolonged break in intensive study, and this is often the only time that a young man can be free of family or professional ties. National Service provided this opportunity for many, but independent initiative now is viewed with suspicion by appointments committees.—I am, etc.,

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SIR,—I was most interested in Mr. Neville Stidolph's article on the training of surgeons (9 November, p. 379). I hope his suggestions and conclusions will be noted by those involved in the training schedules being developed in this country.

While I was in the Sudan the late Julian Taylor helped to establish the primary F.R.C.S. examination in Khartoum, and quite a number of my junior medical staff successfully passed it. When they tried to follow this up by going to England in preparation for the final examination, they often found great difficulty in getting suitable jobs. It occurred to me that, as the Royal College of Surgeons was responsible for setting them on the path towards full surgical status, it might have been useful for it to accept a further responsibility in placing these doctors, generally the cream of the local medical graduates, in suitable training positions. It could have been possible, perhaps, for the College to have a panel of consultants around the country prepared to accept successful primary candidates from overseas simply on the College's recommendation. I think this panel is still necessary and would be quite easy to arrange.

An important point mentioned by Mr. Stidolph is the demand made by some countries for the return of their graduates immediately on achieving the higher diploma. I have had some experience of this, and can recall the case of one of my junior staff, who was unfortunate enough to come to England and pass the final Fellowship examination at his first attempt two months later. He was back in his own country within a few weeks and was promptly posted to a remote area as junior surgical specialist, without adequate experience or supervision. I certainly feel that a compulsory period of post-diploma work in this country should be introduced for overseas graduates, possibly by some device similar to the post-qualification, pre-registration period now in force for newly qualified doctors. This would, of course, be in addition to any pre-fellowship training, and might in a sense be more valuable as there would be no examination looming ahead. It would give some protection to the graduates against premature uprooting, and would certainly improve the quality of some of the British-trained surgeons now returning to their home countries with the F.R.C.S. Many are, of course, of first-class calibre, and are very good ambassadors, but it is inevitable that, where there is a gross shortage of medical personnel, and even more so of people with higher qualifications, these latter, on returning to their home countries can be thrust into positions of great responsibility for which in some cases they are not fitted. I think the image of British surgery would be enhanced if these diplomats were returned to their countries with something more than letters after their names.

Mr. Stidolph has rightly pointed out that the overseas graduates coming here for training need to have facilities for study, particularly free time, and proximity to centres of learning. However, as they tend to be employed mostly in the peripheral hospitals, where the work-load can be very heavy, their opportunities for study are considerably reduced. I think rotating designated training posts, and the grouping of district and peripheral hospitals into a training scheme under the aegis of a university hospital, perhaps parallel to that designed for the production of consultants for home-consumption, would produce several results. Many more jobs would be made available, more hospitals would be upgraded with consequent improvement in recruiting, and consultants not now directly involved in the training programmes would be given a fresh stimulus in their work.—I am, etc.,

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Brescia–Cimino Shunts for Dialysis

SIR,—Dr. R. McMillan and Dr. D. B. Evans (28 September, p. 781) describe their experience with three patients in which Brescia–Cimino shunts (arteriovenous fistulae) were established and used for access to the circulation in intermittent dialysis therapy.

We have previously recorded our experience in 15 patients in whom Brescia–Cimino arteriovenous fistulae were established for regular dialysis treatment.[1] Our experience now extends to 48 cases, which we have been able to follow on our own regular dialysis-transplantation programme. We have observed these patients for a total of over 330 dialyses months; 23 of these received cadaveric transplants. Two of the transplanted patients are rehabilitated on regular dialysis treatment following rejection of second grafts, and two others following rejection of the first graft. Though we have had many problems, including death, no patient has suffered any complication, cardiovascular or otherwise, which could be attributed to the Brescia–Cimino fistula. Thirteen of our patients have had experience of the Scribner-type external shunt prior to the arteriovenous fistula. They are unanimous in their preference for the latter. None of the group demonstrated increase in cardiac size, deterioration in E.C.G. pattern, or the development of progressive exertional dyspnoea. In addition, 11 arteriovenous fistulae have been established for patients on other regular dialysis treatment programmes, including home dialysis.

The retrospective impressions of Drs. McMillan and Evans on three patients, who between them developed multiple serious and well-known complications of renal transplantation, can only be regarded as a totally inadequate and unfair commentary on the merits or otherwise of the Brescia–Cimino arteriovenous fistula. Control of hypertension is the greatest single indication of successful regular dialysis treatment no matter what method of access to the circulation is employed. Frequency of dialysis and adequate flow rates are critical factors in this context. To achieve the latter with the Brescia–Cimino fistula reasonable expertise in the techniques of repeated venepuncture is essential. Drs. McMillan and Evans present no positive evidence on these critical points in relation to their three cases. As reported at the symposium on the subject at the Dublin Meeting of the European Dialysis and Transplant Association,[2] cardiac complications with arteriovenous fistula are confined to patients in whom hypertension has not been controlled.—We are, etc.,

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[2] *Proceedings of European Dialysis and Transplant Association*, June 1967, in preparation.

Exchange Transfusion and Perforation

SIR,—We were interested to read the reports of Mr. J. J. Corkery and others (9 November, p. 345) and Drs. R. L'E. Orme and Sheila M. Eades (p. 349) on perforation of the bowel in the newborn period as a complication of exchange transfusion. Perforation, however, is only the most dramatic result of mesenteric vascular occlusion, and is not inevitable.

At a meeting of the South West Paediatric Club on 26 May this year, and again at a meeting of the Neonatal Society in London on 17 October, we presented six personally studied cases of neonatal gut infarction. Two of our cases had been preceded by at least one prolonged and technically