volving hospital posts with little or no proper teaching sessions and which, one suspects, are looked upon by management committees as an easy method of filling certain less popular resident posts. This sort of training seems to fall into the same pitfall as undergraduate teaching in the past, in that it is too hospital orientated. Better results might be obtained from giving a much more prominent place to general practice in the medical school curriculum in conjunction with more responsible registrar grades in general practice after the usual house appointments.

Also if family doctors are to participate in hospital work there must be a reduction in the average practice list. This one single factor more than any other could do more to improve standards and attract doctors to general practice. It will need, however, more Government money for medical schools and for general practice.—I am, etc.,

JOHN NEASHAM

Ilkley, Yorks

Accident Flying Squad

SIR,—Dr. Roger Snook is to be congratulated on his papers on the improvement in the design of ambulances (2 September, pp. 569 and 574), a subject that has virtually been neglected by the local authorities. More especially his work on the accident flying squad is one that should be seriously considered by all those intimately associated with the accident services. The work of people such as Collins of Derby, Pym in the Thames valley area, Easton of Yorkshire, and many others has shown conclusively that the old concept that the life of a person unable to survive the journey to hospital was not salvagable anyway is invalid. I have no doubt at all that in the type of accidents dealt with by Snook and others the first ten minutes can not only preserve a life but preserve its quality.

It is pertinent to ask whether such admirable schemes should be limited to areas where there are enough enthusiasts and, very often, enough voluntary support and interest, or whether the time is not now ripe for the organization of such a service to become a national concern. This should surely be considered in the light of the reorganization of local authorities and the changes in the Health Service envisaged in 1974. Those of us interested in improving the accident service nationally should now be thinking of an overall pattern of expert mobile attention immediately available to go to the site of accidents and carry out the initial life-preserving procedures. In many areas such a service could well be based on a major accident department, but in the more rural areas remote from a major accident centre a system based on general-practitioner participation (which has in many areas already proved its worth) should be an accepted part of the scheme and encouraged. Such a national policy, in particular in association with the current plans to improve the skill and knowledge of the ambulance personnel in their initial assessment of cases, could be combined in the creation of an overall national scheme.—I am, etc.,

M. S. CHRISTIAN

Slough, Bucks

SIR,—It would seem that neither Mr. T. J. Orchard nor Dr. J. F. Redden (30 September, p. 831) dispute the need for early medical care but rather the method of organization of the Bath accident flying squad. At present ambulance men cannot carry out intubation, give infusions or drugs, or perform surgical procedures. I strongly favour upgrading ambulance training and responsibility, and one of the best ways of achieving this is for doctors to engage in the practical work of the ambulance service. One of the great benefits of medical attendance at the scene of accidents is the use of the experience so gained in training emergency service personnel. In Bath we have winter lecture-demonstration sessions and a programme of "in-hospital" training, including practical sessions on intubation and infusion. However, teaching the technique is one matter and assessing the clinical situation over a period of time another. Dr. Redden should remember that many general practitioners use intravenous techniques and may even have diplomas or experience in anaesthesia as well as experience from staffing local casualty departments, and any general practitioner wishing to develop an interest in this field is surely just as capable of learning medical techniques as anyone else.

Several factors enter into the method of transport used. The first is a matter of convenience. Having equipment and communications in the car reduces mobilization time and allows freedom of movement when on call. Travelling in a police car makes direct communications on the journey more difficult as ambulance and police radios work on incompatible systems. In this area the average distance to the incident is 5 miles (8 km) and the maximum mobilization time is 1½ min. The average mobilization time for the Derby scheme is quoted as 4 min by Dr. Keith Little (30 September, p. 807). If I drive at 45 m.p.h. for 5 miles my journey time will be 7½ minutes, and 1½ minutes for mobilization makes a total of 9 minutes for arrival at the scene. This compares with a journey time of 5 minutes at 60 m.p.h. over 5 miles (a reasonable speed for a police car) and 4 minutes (average) for mobilization, making a total of 9 minutes for arrival at the scene. In rural areas high speeds can be maintained safely by the ordinary motorist without arriving at the scene in a state of adrenal overactivity.

Contrary to Mr. Orchard's conclusions, the costing of the scheme was for all 132 accidents attended. This cost is then deducted from the Road Research Laboratory figures, for which I am not responsible. Very few of the 132 calls could be regarded as wasted. When considering the effect of early medical treatment it must be remembered that patients can and do die from simple, reversible causes as well as multiple trauma. Two of the cases (2 and 6) can be paired with fatal cases from similar pathology. It is not enough to provide fast transport to hospital in place of early medical treatment. This will not help the trapped nor the critically injured. The equipment carried is basically similar to that carried by the Derby team except for the latter's extra anaesthetic and more elaborate surgical equipment—neither of which has been needed and both of which could be easily obtained from the accident department should the occasion arise. (Chest aspiration equipment, though

not detailed, is included in the intubation set and includes chest trochairs and Heimlich valves.) I think it would be wrong to conclude that any one method of organization is best. Each scheme should be an adaptation to the needs of the particular area.

In conclusion I can only say, somewhat defensively, that the system described actually works in practice, has not interfered with normal work, and has benefited the ambulance service training already. Perhaps the greatest difficulty lies in condensing a 220-page university report containing 47 colour photographs and numerous charts and diagrams into a five-page article for publication. I invite anyone still unconvinced to inspect the scheme in its continuing form before suggesting it is unnecessary or inadequate.—I am, etc.,

R. SNOOK

Bath

Admission to Geriatric Units

SIR,—I feel that I must protest about the difficulty of placing acutely-ill old people in hospitals in this area. It is almost impossible to get emergency admissions into the local geriatric unit and they must therefore go to acute general medical beds. These are always in short supply and resident medical officers are not surprisingly reluctant to fill them with potentially chronic geriatric cases. I am not critical of any of my colleagues but of the hospital admission system. If a patient merits urgent hospital treatment it should be available, preferably in these cases in a geriatric unit. Unfortunately, with the closure of more geriatric units and private nursing homes and the increasing number of old people in the population this is a problem that is going to get very much worse in the near future.—I am, etc.,

P. KALLIS

Manchester

Rhesus Isoimmunization and Twins

SIR,—Further to our letter (2 September, p. 587) we would like to review another case of multiple pregnancy in association with Rhesus Isoimmunization.

A gravida-5, aged 27 years, was found at about 22 weeks' gestation to have a twin pregnancy. She was group O rhesus negative, probable genotype cde/cde, and her husband was group O rhesus positive, probable genotype CDe/CDe. In 1967 she had a twin pregnancy, twin one being stillborn owing to intrauterine asphyxia. In 1968 she came for her first antenatal visit at 34 weeks' gestation. She was found to have anti-C 1/64 by enzyme and 1/64 by I.A.G.T., anti-D 1/128 by enzyme and 1/512 by I.A.G.T. Intrauterine death had occurred and she was subsequently delivered of a still-born fetus with hydrops. In 1969 she had a 24-week and in 1971 a 28-week abortion of a hydropic fetus, and the antibody titres were: anti-C 1/32 by enzyme and 1/16 by I.A.G.T., anti-D 1/64 by enzyme and 1/64 by I.A.G.T.

In the present pregnancy ultrasound showed the placentas to be in the upper segment posteriorly and the fetuses lying side by side. Antibody titre was weak saline anti-C+D and anti-C 1/128 and anti-D 1/256 by I.A.G.T. Amniocentesis of both sacs was possible and the results extrapolated back to 23 weeks (Table). Plasmapheresis was begun and it was intended to attempt intrauterine transfusion of both fetuses. Unfortunately, neither fetal heart could be heard after three days. Later the patient