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 Bickerstaffe
John Radcliffe Hospital, Oxford OX3 9DU


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, customs which 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 any 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 wholetime 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 morbidities 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 retroperitoneally 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 judgment 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, failure to provide 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 Lewes 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." 11

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

PRADJ Datta
Bignold Hospital, Wick, Caithness, Scotland


Fetal monitoring in labour

SIR,—Dr 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 gynaecological practice by mounting randomised trials.1 2 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 discipline in respect of these beliefs.

Dermot McDonald
National Maternity Hospital, Dublin

ADRIAN GRANT IAIN CALMERS
National Perinatal Epidemiology Unit, Oxford


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 fibrict 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 back to 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 respondents.

Andrew Herxheimer
Editor
ANTHONY LAND
Head of publishing
Drug and Therapeutics Bulletin, London WC1N 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, Garcia M, Mun P, Nolasco A. 10-14 years trends in the Journal’s publications. N Engl J Med 1985;312: 1521-2.