of China, the more I came to understand and sympathize with that point of view. To them the be of study is the location where needles should be placed is misconceived. If you want to make acupuncture work, attention will have to be directed not to the acupuncturist, but to screening patients to see if popping needles at random into those susceptible to hypnosis and who have a strong motive for it to be successful. It must be remembered that the Chinese people are, with good reason, intensely grateful to Chairman Mao, and that has throughout championed traditional medicine, the only medicine available at the time for the masses who supported him during his years of turmoil. Understandably, motivation for acupuncture to be successful is great.

It would be an easy matter to test whether accurate sitting of the needles or the mental approach of the patient is the more important factor in achieving success. There would be no difficulty in obtaining the necessary expenses for trained acupuncturist to travel to Britain and exhibit his skills at any emergency operation, or at any routine operating list for general surgery in the country. If he could sufficiently predict a success rate of nil, I believe that faced with cholecytectomy, acupuncture needles bear a similar relationship to ether as does a bottle of coloured medicine to penicillin in the treatment of septicaemia.

I would stress that I write not to denigrate acupuncture—far from it—but to express my belief that, if someone can explain hypnosis to me, I am confident that the secret of acupuncture will be revealed at the same time. I concur entirely with the view that “acupuncture is an effective use of hypnosis. This in no way diminishes the value of acupuncture, but it does place it in a class of phenomena with which we are partly familiar.”—I am, etc.,

ROBERT MACINTOSH
Nuffield Department of Anaesthetics,
Radcliffe Infirmary,
Oxford

Surgical Wound Infections

SIR.—The design of surgical wards probably has a profound influence on the rate of wound infection, but this has not been the subject of clinical trial. A sequential review of the infection rate in Aberdeen after moving from a pavilion-type ward to one with single rooms and plentiful ventilation has shown a reduction of wound infections, even of endogenous type by intestinal organisms.1,2

In the course of two trials on the prevention of surgical wound infection by cephalosporin,3,4 we have found that the infection rate in comparable wards is less in the War Memorial Hospital, Whitby, than in Scarborough Hospital. The latter is a district general hospital with large, open, “nightingale” wards, each of 30 beds, in which all types of surgical patient are nursed. The Whitby hospital is a cottage hospital with several wards for one or two patients and eight-bedded male and female wards for both medical and surgical patients.

In wounds with no potential for endogenous infection (“clean”) there were no infections among 117 Whitby cases compared with 20 (5-1%) among 388 Scarborough cases ($x^2 = 6-25, P < 0-02$). In contaminated cases (involving the opening of hollow viscosa or the excision of infected lesions) the infection rate was low (in Whitby (11/91), 12-1% compared with 53/549, 15-9%), but the difference was less significant ($x^2 = 0-55$).

It is unlikely that the better results in the Whitby hospital are due to the design of the operating theatres (which is similar in the two hospitals) or the nature of the operations (complicated operations were excluded from the comparison because they were done in Scarborough). The contrast is more likely to be in the size of the wards, which are much bigger and busier in Scarborough.

Probably the ideal milieu from the point of view of avoidance of endogenous wound infections is a small home. We have recently operated (for hernias, varicose veins, etc.) on 111 patients who stayed in Scarborough Hospital for only 24 hours altogether. There were no wound infections in this series.—I am, etc.,

A. V. POLLOCK
Scarborough Hospital,
Scarborough, Yorks.


Late Advertising of Hospital Posts

SIR,—Professor R. S. Illingworth (4 August, p. 289) asks for more consideration for junior doctors in the timing of advertisements for hospital posts. The contents of many such advertisements much resemble those of a job advertisement. Relatively few give any indication of the nature of the job (apart from medical or surgical, etc.), the experience required, or the opportunity to gain whilst doing the job. Postgraduate faculties are rarely mentioned. It may be argued that a telephone call to the hospital secretary is all that is required to obtain further details. The last time I rang a hospital secretary for information about a post, in particular the number of junior staff on the firm, I was given quite incorrect information. Professor Illingworth also points out that sometimes applications have to be sent in almost within hours of the advertisement appearing. Some hospital administrators do not seem to think that such haste should apply to them. One teaching hospital took three months to write and tell me that I had not been offered a post.

If hospitals wish to attract high-quality junior staff, then the standard of advertising must improve. I feel that hospital consultants have an important part to play in this. They should vet all advertisements for their junior staff and insist that administrators should place comprehensive advertisements. After all, it is the consultants and their junior staff, not the administrators, who suffer if only unsuitable candidates apply. Some hospitals place exemplary advertisements—why can’t the rest?

Another problem is whether a post is really needed. The reports of the census of what constitutes a resident post. I have just been offered a locum registrar post which is non-resident—yet I am compelled (by the administrators, not the consultants) to live in when on call. This is every other night and alternate weekends. If one is to be resident for the maximum recommended time, then surely the post should be resident. Alternatively, if one is forced to buy appointments are advertised very late and within a few days of the start of the appointment.

With regard to the first complaint he will be pleased to know that real efforts are being made to synchronize the junior hospital appointments throughout the U.K., with growing success. With regard to the second there is a reason why some preregistration appointments are advertised late and it is difficult to see how it can be avoided. Preregistration appointments are taken up by the newly qualified doctor and the posts are allocated by computer or otherwise before the final examinations in June. Inevitably a few students fail the exam and are therefore unable to take up their appointments in August, so that they cannot be advertised in July. This does not apply of course to S.H.O. appointments, but here I am sure Professor Illingworth knows that not a few S.H.O.s leave their posts before termination through having obtained a registrar post or for other reasons, so that a late advertisement is necessarily evidence of “administrative inefficiency and incompetence” or “thoughtlessness for the doctors.”—I am, etc.,

ARNOU S. ALDERS
Director and Dean of Postgraduate Studies
Welsh National School of Medicine,
Cardiff

Promotion of Research on Deafness

SIR.—According to the Chronically Sick and Disabled Persons Act, under section 24, the Department of Health and Social Security was charged in 1970 with the responsibility of collating and presenting to the Medical Research Council information on the case for an institute of hearing research with the function of co-ordinating and promoting research on hearing and assistance to the deaf and hard-of-hearing. This report, compiled by Dr. Annette Rawson using information