Correspondence

There is a simple solution. The report points out in paragraph 24 that much of the development of individual interests and special skills begins in the later years of senior registrarship. This is so and should continue to be the case. The senior registrar is having one of the best times of his professional career. Unfortunately this beautiful period is bedevilled with the uncertainty of obtaining a consultant post. This would be partially relieved by the completion of his vocational training and his registration in his specialty; it would be further relieved if he was given increasing clinical responsibility, having complete clinical charge of a small number of beds while still retaining the service commitments of the senior registrar post on the unit in which he works. The responsibility of the consultant grade is to see to it that the trained senior registrar does have this facility to develop his individual skills and interests, and at the same time to exercise gentle restraint without which the young consultant may play, so heavily armed by modern techniques, commit such things to his patients and to his professional career.

It is at this stage that the mobility mentioned in paragraph 25 can take place. It may be, and it must be, that the size of the unit or the nature of the work would prevent the whole young consultant having more than, say, four beds out of 40, but he should be able to move to another unit and acquire greater responsibility, so that he eventually acquires full clinical charge of an average unit of about age 37 or 38 or at present. He is unlikely to move after acquiring full consultant status with control of a unit. Home and family ties, financial reasons, relations with general practitioners and fellow consultants who feel his special skills and interests with their cases, will all prevent his mobility after the age of 38 to 40.

The final consideration is financial. It always is. The report is as blind to this as the practical effects of its recommendations. If the report is correct that men after eight years of postgraduate training should be given full consultant status, then they should be paid accordingly. If the recommendations of the report were put into effect there would be an immediate increase in salary for a large number of registrars and senior registrars, and I would suggest that the appropriate adjustments for consultants already in post. The report makes an excellent case for this for submission to the Review Body. And it is after all a Ministerial report and not a submission from the B.M.A. or the Joint Consultants Committee.

If there is to be gradual progress to full consultant standing between 32 and 37 to 38, then it will be necessary not only to link the bottom rung of the consultant incremental ladder to attainment of minimum consultant status at about 32, but also to extend the consultant incremental ladder upwards for, say, another seven years after the attainment of full consultant status at 37 or 38 to about 45, so that the entire consultant incremental ladder would run from 32 to 45. This plan would overcome one of the problems of the junior medical staff at present so disfigured by the severe check to their progress from senior registrar to consultant. It would allow for expansion of the consultant grade at a controlled pace with expansion of the units in which they can work, and it would not break up the team system so essential in modern hospital work as would the sudden eruption of a rash of consultants all of equal status.—I am, etc.,

K. S. MULLARD.
Wessex Regional Cardiac and Thoracic Surgical Service, Chert Hospital, Southampton, Hants.

Cost of Medical Publications

SIR,—I had been wondering whether someone from Excerpta Medica would reply to the criticisms in the articles on the cost of medical publications which appeared in B.M.J. (26 July, p. 227). Now, after 12 weeks, we have the letter from Mr. P. A. Warren, director of the Foundation (18 Octo-

ber, p. 219). Perhaps Charles C. Thomas, Academic Press, and Pergamon Press, which were also criticized, will now feel moved to reply. I find it worrying that these firms should ignore criticisms of their prices and shun off an editorial in one of the world’s leading medical journals.

Turning to Mr. Warren’s attempt “to provide enlightenment,” his letter contains no facts, figures, or answers. Of course, the costs of production are the same for a non-profit-making concern as for any other. But because it does not have shareholders to reward it should be ploughing back its profits in some way. Is Excerpta Medica doing so?

Mr. Warren gives no account of how his organization came to price the volume Diabetes at £22, nor of what efforts he is making to reduce this price. I doubt if he will agree to a high, in the future. What, I wonder, does he expect the cost of the corresponding volume for the 1970 international diabetes congress to be?

Mr. Warren says that organizers of congresses “almost invariably insist on the ‘heavy and so shiny’ paper, the heavy cover, the specially designed dust jacket, etc.” Clearly I am not in a position to deny this statement, but I express surprise at it. Does Mr. Warren try to persuade conference organizers to reduce costs? And does he fail?

Does Mr. Warren know how many copies of the conference proceedings he has published are sold (a) to private individuals and (b) to libraries? I would be very glad to have from him—and from a representative of Academic Press—an assurance that he does not calculate his retail prices on the assumption that there is a captive audience of medical libraries which feel obliged to buy his publications, and that other sales are immaterial.

A final point. Now that Pergamon Press is under new management, would a representa-tive care to answer the letter from Miss E. M. H. Green, librarian of the British Dental Association (9 August, p. 356), who reported that the cost of Archives of Oral Biology was 5 guineas annually to a private subscriber but £40 to a library? The point seems worth answering.—I am, etc.,

F. C. HARRIS, Chairman, Medical Staff Committee, West Suffolk General Hospital, Bury St. Edmunds, Suffolk.

Obstetrics and the General Practitioner

SIR,—Recent rumours and trends have suggested that the days of the general-practitioner obstetrician may be numbered. We feel that this would be a misguided step of the first order.

In this area many general practitioners have the time and interest, and also the co-operation of a first-class midwifery team, to enable them to carry out first-class obstetric practice. At the present time this may well be conducted on the district in a high proportion of cases, but even looking to the
Radiology's New Chance

Sir,—The creation of university departments of radiodiagnosis which was emphasised by Professor J. H. Middlemiss (11 October, p. 107) is, I think, a signal for a new, and a salutary role. Two important principles are ignored—namely, that (1) the general practi-
cioner is a principal in his own right, and, (2) general practice is a viable entity, designed
to function in conjunction with, but never subject to, any particular specialty. General
practice obstetrics is a part of this entity and the G.P., provided he has the necessary skill
and training, has a right to practise as the principal in the field.

The specialist obstetric unit and general-practitioner obstetric unit are separate and
distinct both in role and character, and must remain so whatever the Hospital roof or 20 miles (32 km.) apart.

The former accepts those cases that the general prac-
tioner considers are in need of specialist care and

Frank Wells.
Ipswich, Suffolk.

ROY WEBB.
Ipswich, Suffolk.

REFERENCES
1 Unpublished observations.
2 Personal communications.
3—The report of the council of the Royal College of Obstetricians and Gynaecologists on Hospital Obstetrics and the General Practitioner "has filled me with concern and dismay. No doubt many other general practitioners will feel the same. What is perhaps more alarming is that the Royal College of General Practitioners supports this report.

In essence, it is a complete take-over of general-practitioner obstetrics, with the relegation of the general practitioner to the position of a glorified houseman. This will certainly be unacceptable to the majority of general practitioners, who at the moment place their own right, and practise it with skill and efficiency to the satisfaction of their patients with that personal touch that is peculiar to the art of good practice.

It is the old, old story. We repeatedly hear the old lip-service phrases about general practitioners, "backbone of the profession," etc., etc., but inevitably in any plans for the future who will be responsible for a second-
duct of normal obstetrics, where help can be sought if things go wrong, but where the outstanding co-operation which exists at present between family doctor and domiciliary midwife can be continued. The pattern of 12-48-hour discharges (as in the Cardiff scheme) under these circumstances should become the ideal obstetric plan of the future. Further training in obstetrics is an essential part of vocational training for junior doctors, leading to one year of experience in normal obstetrics to the tune of 25-35 cases per year for an average size list of 2,500 patients.

It is our opinion that the proper practice of obstetrics is within the content of modern general practice, that it is a physiological process in which the general practitioner and midwife must be fully involved, and that the rapport established with the family by his performing this function is an essential part of family doctoring.—We are, etc.,

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