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Adoption into Family with Mentally Handicapped Child

SIR,—I am becoming increasingly concerned about a widely held policy of adoption societies in this country. It appears they will not consider parents who would like to adopt a child and have a mentally handicapped child. A recent case has come to my attention, and my efforts to help have failed.

A healthy couple wanted to adopt a baby ; out of four pregnancies there have been two miscarriages, an anencephalic stillbirth, and a child with Down's syndrome. This child is cared for devotedly at home, and is now 3½ years old and making good progress. Naturally, these parents do not wish to embark on a further pregnancy, but have applied to five well-known adoption societies, only to be turned down without an interview. Some agencies admitted that it was because of the mentally handicapped child, but suggested that if the handicapped child were placed in an institution then the parents would be considered.

Is it not time the adoption societies reviewed their ideas and were brought up to date ? By no means is every handicapped child an unmitigated burden to a family nor detrimental to the family psychodynamics, while many of us know of mentally handicapped children who have added something positive and cohesive to the functioning of the family unit to the mutual benefit of all. The psychological stability of many marriages would not have withstood the trauma of four pregnancies resulting in no normal children, and it is to the credit of these parents that they function so well. This is but one of several cases where we have been asked to help, but it appears that even a psychiatrist's recommendation is of little or no value.

Do the medical advisers to adoption societies have any knowledge of family psychodynamics where problems of mental handicap are concerned ?—I am, etc.,

Queen Mary's Hospital for Children, Carshalton, Surrey. JOAN BICKNELL.

Immigrant Doctors

SIR,—In his letter (8 March, p. 645) Dr. D. C. Prior commented that an examination will be useless in either restraining the number of immigrant doctors or testing their practical ability. I would disagree with this view on the following grounds.

By screening the immigrant doctor's knowledge a proper standard will be maintained in Britain because different universities in different countries have different standards of education.

As the examination will include an English test—the language problem, which has currently excited so much comment, would be nipped in the bud.

The appointments will not only be made on the possession of the certificate, but will also take into account the career in the universities of qualification and previous experience, so that only a suitable candidate will be appointed to a particular job. This will be better than short listing twelve candidates (out of 60 applicants) for a pre-registration job where all are equally good, or, in certain circumstances, too qualified for it. This would surely minimize the harassment to a newcomer in an unknown country.

Dr. Prior thinks that the examination will not reveal "the practical ability so necessary in the peripheral hospital where majority of such doctors will be employed." Granted, but which examination does ? Does the possession of a M.R.C.O.G. or F.R.C.S. mean that the person is an accomplished gynaecologist or surgeon ? It only means that he or she has the theoretical background to practise that specialty and is therefore less prone to cut the recurrent laryngeal nerve in thyroidectomy or the ureters while performing hysterectomy, because his knowledge of surgical anatomy was tested in the examination. Moreover, peripheral hospitals are training centres, so why should the junior immigrant doctor be expected to be able to apply forceps and do manual removals on his own, when a junior British graduate expects to learn this during the same tenure ?

By overseas appointment through universities I did not plead for a progressive career for the immigrant doctor in this country, but I suggested an "exchange programme" whereby the candidates might work in a peripheral as well as teaching hospital for a short time. These will be the potential consultants in their countries of origin, so it is only fair that they spend some time in a teaching hospital, where they can have teaching facilities. Training in a peripheral hospital can make a good surgeon or gynaecologist, but not, as we all know, a good teacher.—I am, etc.,

Queen's Park Hospital, Blackburn. M. K. DATTA.