BRITISH MEDICAL JOURNAL

SATURDAY 30 JANUARY 1971

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5743 BRITISH MEDICAL JOURNAL 1971 VOLUME 1 243-300 WEEKLY PRICE 7s
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR TELEPHONE 01-387 4499

CORRESPONDENCE

Correspondents are asked to be brief

Obstetric Anaesthesia

SIR,—The labour wards and theatres of an obstetric department work as hard by night as by day. If a unit of sufficient size, "more than 2,000 deliveries . . . annually" (Dr. Gordon Taylor, 9 January, p. 101) justified the appointment of an anaesthetist "without other duties" it would be necessary to appoint at least three to provide a 24-hour service. This would obviously be impossible as well as unnecessary.

But the fact that there is not an obstetric anaesthetist with no other duties does not make it "impossible to provide a 24-hour regional analgesic service." Every obstetric registrar or lecturer on appointment can learn, and quickly master, the caudal technique. In this way an efficient service is available. Over 6,000 patients at Oxford have cause to be grateful for caudal analgesia provided in this way, and many visitors have come to learn the technique prior to practising it and teaching it in departments elsewhere.

When the ideal to which Dr. Gordon Taylor referred is not obtainable an effective interim service is within the reach of all.—I am, etc.,

JOHN STALLWORTHY

Nuffield Department of Obstetrics and Gynaecology, Churchill Hospital, Oxford

SIR,—May I comment on Dr. Gordon Taylor's research into this subject (9 January, p. 101)? The extensive survey, which was conducted at the request of the Obstetric Anaesthetists' Association, confirms the general impression held by many of us. The staffing of obstetric units in the U.K. by competent anaesthetists and the supervision of trainee anaesthetists in this field are deplorably deficient. Until proved otherwise, it must be considered a major factor contributing to the large number of maternal deaths associated with anaesthesia. The effect of the deficiency on neonatal morbidity and mortality is at the present incalculable, but it is possibly significant to note Dr. Taylor's finding that in over half the hospitals he surveyed an anaesthetist was first on-call for neonatal resuscitation. The less dramatic problems of adequacy of safe relief from pain in labour also come well within the province of the anaesthetist nowadays.

That the complex, frequently urgent, challenges of anaesthesia, resuscitation, and adequate analgesia are left virtually exclusively in the hands of unsupervised, relatively untrained, and frequently harassed junior anaesthetists is surely an intolerable situation: unfair to trainees as well as to the patients. The situation is summarized in Dr. Taylor's finding that in 344 hospitals the total consultant anaesthetist sessions nominally devoted to obstetrics numbered 222, and in 242 of these hospitals there was no such official commitment.

The Obstetric Anaesthetists' Association urges that consultations between representatives of all the professional bodies concerned be started without delay, with the objective of remedying the situation.—I am, etc.,

J. SELWYN CRAWFORD

Birmingham Maternity Hospital, Birmingham 15

Government Control of Amphetamine Abuse

SIR,—The B.M.A. Working Party on Amphetamine Preparations recomended their control by government regulation,[1] but the British Government decided that control should be on a voluntary basis. In Ipswich, where this voluntary control was put into effect, it succeeded in preventing any rise in amphetamine abuse.[2] Not until March 1970 was the urgent need for government control recognized and the proposed Misuse of Drugs Bill published.[3] In contrast, control of the import, distribution, and sale of amphetamine preparations was imposed by the Irish Government at the end of 1969 (Medical Preparations (Control of Amphetamines) Regulations, 1969). This provided an opportunity to assess on a national scale the effectiveness of the type of control recommended by the B.M.A. Working Party.

Urine samples from boys admitted to a custodial establishment in Ireland during the last quarter of 1969 and the first quarter of 1970 were analysed by gas liquid chromatography for the presence of amphetamine.[4] Amphetamine was detected in the urine of 11·4% of the first sample of 123 boys, but in only one of 171 samples of urine in the second period. Similar tests have been done on boys in English remand homes on several occasions[5-7] since 1965 (Table). The percentage of positive samples fell from 17·2% in 1965 to 2·0% in 1969.

Amphetamine abuse had reached its peak incidence in Britain in 1965. Even though the Drugs (Prevention of Misuse) Act, 1965, probably did not give effective powers for controlling the abuse of amphetamines,[8] growing public alarm discouraged their availability. It is therefore not surprising that the number of boys in English remand homes with amphetamine in the urine fell by 88% between 1964 and 1969. However, the fact that amphetamine was still detected in 2% of the samples four years after the peak incidence had been reached shows that public discouragement and voluntary restraint of amphetamine availability are ineffective controls and exert their influence relatively slowly.

Amphetamine abuse came to Ireland later than elsewhere in Britain.[9] The finding of 11·4% in the Irish samples at the end of 1969 corresponds to the relatively high value occurring in London when amphetamine abuse was approaching its peak. The percentage of positive samples in Ireland might well have exceeded the level reached in the last quarter of 1969 had the timely prohibition on the distribution and sale of amphetamine preparations not been intro-