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CORRESPONDENCE

Correspondents are asked to be brief

Obstetric Anaesthesia Services

SIR,—We would like to comment on Dr. Gordon Taylor's paper on obstetric anaesthetic services (9 January, p. 101). It is obvious that rapid advances in patient care without a corresponding increase in available staff must lead in many fields to a situation where it can be shown that the resources allotted are less than ideal. We have tried to analyse the situation in anaesthetic emergency work in a recent paper.[1] The problem is to decide how to allocate the available resources in an imperfect situation.

The first step seems to us to examine the total demand on these resources. After preliminary data collection priorities should be assessed, and like Dr. Gordon Taylor we would regard obstetric anaesthesia as high on any priority scale. However, it seems to us that to focus attention on one aspect of anaesthetic work in isolation can lead to a situation in which resources are allocated by rival pressure groups. Some, like that to which Dr. Taylor belongs, will support worthwhile causes. Others, displaying more zeal than reason, might prefer the dramatic to the rational.

The article states that in England and Wales there are between three and four hundred hospitals to be covered for obstetric anaesthesia, and latterly for obstetric analgesia. Many of the patients require anaesthetics in an emergency situation. About 30% of these hospitals have more than 2,000 deliveries annually. In our survey of emergency anaesthetic services, we found that the London Hospital is responsible for about 2,000 deliveries per annum, and Northampton General Hospital for 3,500. These hospital confinements generated 32 and 41 obstetric emergency anaesthetics respectively in eight weeks, with an average duration of 41-45 minutes. These figures show that each 1,000 deliveries per annum gives rise to a demand for about two anaesthetics per week. Dr. Gordon Taylor suggests as an ideal that an anaesthetist should be reserved solely for obstetric surgery in most hospitals. This would mean three anaesthetists in each hospital working a one in three rota (that is, a 56-hour week). Presumably in England and Wales this would mean between 750 and 1,000 anaesthetists, all of whom should be of considerable experience. If the work load assumed above is correct for the average hospital (2,000 deliveries a year, generating up to five calls per week), this implies an occupancy of their time of the order of 3%. There are about 2,500 anaesthetists of all grades in England and Wales. Thus the result of examining one aspect of the anaesthetic service in isolation is a proposal to use one-third of the total available manpower to provide a service requiring rather less than one-thirtieth of their duty hours.

We do not, therefore, believe that such a service can be provided or ought even to be suggested. There is no doubt that every anaesthetist must make it his business to see that this major area of work is properly covered, including such provision as is possible for analgesia. This in our view is more likely to be obtained if we strive for something sensible rather than giving up in dismay when reproached with ideals which on analysis turn out to be assumptions made in a data vacuum.—We are, etc.,

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1 Taylor, T. H., *et al.*, *British Journal of Anaesthesia*, 1969, **41**, 70, 76, 167, 357, 362.

Murphy's Triad

SIR,—In your leading article on appendicitis in infancy (12 September, p. 599) you state that: "Murphy's classical triad of appendicitis is pain, vomiting, and fever." Sir, this is different from what I have always understood and taught. In such a matter, I suppose the only authority to whom one can appeal is Murphy himself, whom I hope you will accept. In the account of his own personal experience of two thousand operations for appendicitis,[1] John B. Murphy mentions ". . . the symptoms in the order of their occurrence may be mentioned as: first, pain in the abdomen . . . second, nausea or vomiting . . . third, general abdominal sensitiveness most marked in the right side, or more particularly over the appendix."

Elevation in temperature he names as fourth, even though stressing its importance. In his discussion it is evident that it is not a constant feature throughout an attack and the elevation of temperature may be absent at certain stages and in certain circumstances: "In calcular obstruction it does not appear until the twentieth or twenty-fourth hour after the beginning of the pain"; again, "The temperature may all subside within twenty-four hours after the onset"; and "In two cases of perforative appendicitis . . . the patients were walking around with normal pulse and temperature." Thus Murphy in 1904 recognized that a raised temperature at any given stage of the attack is not invariable and is not an essential feature in establishing a diagnosis. This has also been the experience of most surgeons since then.

Therefore I would submit that "Murphy's triad" (a term not coined by Murphy himself but by his successors) should properly comprise (1) pain, (2) nausea or vomiting, and (3) tenderness over the appendix