who qualify by means of a diploma alone is about 120 a year. Even these doctors do not constitute an extra source of manpower, as implied by Maynard and Walker⁷ in their critique of the Todd Report, since they are part of the medical school populations on which the Todd estimates were based.

There is obviously still some confusion between stocks and flows. I made the point that Irish doctors represent about 2% of the junior hospital stock at any one time. In order to relate this to movements of these doctors it would be necessary to know the numbers coming in, the numbers leaving, and the average length of stay. This is an important point; the often rather complex relationship between flows and stocks is a common cause of misunderstanding, which I hoped that my model might help to resolve.

I am quite prepared to go on defending my conclusions as long as necessary. Meanwhile, I should like to express, publicly, my own gratitude to the General Medical Council, the University Grants Committee, the Examining Board in England, the DHSS, the SHHD, and others for their great assistance in supplying data and helping me try to understand it.

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¹ Review Body on Doctors' and Dentists' Remuneration Report, *Evidence from the Health Departments*, March 1976, 2, Statistical appendices, Appendix 2.

² Report of a meeting to discuss preregistration house officer posts held on 4 May 1976 at Church House, Westminster.

³ *British Medical Journal*, 1977, 1, 316.

⁴ *British Medical Journal*, 1976, 2, 1269.

⁵ Parkhouse, J, and Palmer, M K, *British Medical Journal*, 1977, 2, 25.

⁶ Parkhouse, J, *British Medical Journal*, 1977, 2, 834.

⁷ Maynard, A, and Walker, A, *Lloyds Bank Review*, July 1977, 24.

Normansfield inquiry: disclosure of information

SIR,—Your legal correspondent's report (14 May, p 1291) on confidentiality and the three wise men says that Dr Lawlor was persuaded to attend an independent consultant psychiatrist in 1972 and that the chairman of the inquiry disclosed at least some of his findings. Later my name is mentioned. I think most readers would reasonably conclude that I was the independent psychiatrist. I am grateful to your correspondent as this was the first and only intimation which I have had of the disclosure of my "personal and confidential" report. Surely in equity one should have been notified beforehand by the chairman of the Normansfield inquiry.

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An epidural service

SIR,—Dr J A Lee surely misses an important point in his letter (8 October, p 958) on tracheal intubation after inadvertent spinal anaesthesia occurring in maternity patients following epidural analgesia. It is not merely apnoea that causes alarm in this situation but that scourge of obstetric anaesthetics, Mendelsohn's syndrome. Gastric stasis and vomiting are common throughout pregnancy, and even more so in labour, when aspiration and inhalation of gastric contents readily occur. Therefore speedy and accurate in-

sertion of a cuffed endotracheal tube, while an assistant applies cricoid pressure, is mandatory for any pregnant woman who is rendered deeply unconscious or paralysed for whatever reason, if maternal mortality and morbidity are to be kept to a minimum.

KATHRYN HARTLEY

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SIR,—We have followed the correspondence on epidural services with interest and note the various pleas for and against an anaesthetically based service. Dr J A Lee makes the telling point (8 October, p 958) that all doctors can resuscitate the apnoeic patient without tracheal intubation. This holds in most situations but is not acceptable in obstetrics, where the risk of acid aspiration after vomiting or regurgitation of gastric contents is so high. In these circumstances expert intubation is necessary to protect the airway and can only be achieved by a trained anaesthetist or someone who has had a thorough training in resuscitation, including intubation.

So, though agreeing with the principle of obstetricians running their own epidural service, as Mr A B W Taylor and others describe (6 August, p 370), we feel that this should be qualified. It is absolutely essential for patient, safety and, as Dr J M Anderton points out (24 September, p 832), for the preservation of our good record in the United Kingdom, that a resident anaesthetist be available where an epidural service is provided; or that obstetricians taking part in the service are well trained in full resuscitation.

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SIR,—Dr J Alfred Lee writes (8 October, p 958) that after epidural block for delivery "it is quite certain that very occasionally a total spinal injection will result . . . with severe cardiovascular collapse and apnoea." Dr Lee, however, believes that obstetricians can be taught successfully to ventilate an apnoeic mother with a bag and mask. Of course, it is reasonable to expect that any doctor should be capable of ventilating an apnoeic patient. A success rate of 95%, or even 80%, would be excellent when the need arises from a random, unexpected event such as cardiac arrest or drug overdose; the practitioner is doing his best and there is nothing to lose. However, when the cause of the apnoea is a predictable—even if occasional—complication of epidural analgesia, especially in an otherwise fit young woman, then the operator must *always* be able to manage this complication. I do not believe that an obstetrician, unless specially trained and frequently retrained to maintain these skills, could certainly deal with the problem. Furthermore, it is not easy to maintain the airway and an airtight mask fit so as to ventilate a patient with a bag and mask in the lateral position (essential to prevent aortocaval compression). Even an anaesthetist may have difficulty in this emergency par excellence but is trained to carry out quickly any manoeuvre necessary to ensure oxygenation of the patient.

If it is an obstetrician—and maybe a junior obstetrician—who carries out the epidural

block and is dealing with the airway, who will handle the circulatory problem, and, as important, check on the welfare of the baby? After all, this is a rare but treatable emergency which should never result in the loss of a maternal or fetal life. In our unit the anaesthetist always checks, before carrying out an epidural block, that all resuscitation equipment is at hand. If an emergency occurs, then the obstetrician is available to decide whether action is necessary to deliver the fetus.

I agree with Dr Lee that epidural analgesia for delivery should be more widely available but only if it can be supplied safely. I do not believe in demarcation disputes in medicine and some obstetricians with their teams might meet the required criteria for safety, but they would be a minority. The practical solution, however, is to increase the number of anaesthetists working in obstetric units.

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Changes in obstetrics

SIR,—On rereading the interesting interview with Professor Richard Beard, "Changes In Obstetrics" (23 July, p 251), I was disappointed to find no mention of obstetric anaesthesia and analgesia. Surely modern anaesthetic expertise must have some favourable influence on maternal and neonatal morbidity and mortality? When I retired from the consultant staff of St Mary's Hospital, London, in 1972, epidural analgesia was being extensively employed in the obstetric unit. If this is still the case does Professor Beard consider that it has made a worthwhile contribution to the comfort of the mother, as well as to the safety of herself and her child?

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* * * We sent this letter to Professor Beard, who replied as follows—Ed, *BMJ*.

SIR,—Dr Thornton is quite right to point out the unfortunate omission of any mention of the contribution the anaesthetic services have made to modern obstetric care. At present we are fortunate at St Mary's that our anaesthetists are able to provide an "on demand" epidural service for all our patients, 40% of whom ask for it. We are also fortunate in having enough anaesthetists but I recognise that most hospitals do not. I would hope that increasingly it will be the obstetricians who provide the epidural service in hospitals where anaesthetists are in short supply.

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Depression in men and women

SIR,—Further to your interesting leading article (1 October, p 849) in which you quote Pollitt's conclusion that endocrine explanations are more convincing than psychosocial ones for the greater prevalence of depression in women, depressed men may be more inclined to turn to alcohol instead of the doctor, as