their qualities and experience is to be overcome. Successful publicity campaigns have been organized in a number of countries to put this across." "A steady growth over time in the proportion of aged persons might produce a dangerous secular decline in manpower resources and productive capacity of a country, unless an increasing number of aged workers remain in employment."

Conclusion

Study of the sources and data reviewed herein, and of much other material, provides very strong evidence that in both Great Britain and the United States the trend of opinion is that the time has arrived for a thoughtful reconsideration of the customary, and particularly the compulsory, chronological retiring-age. Some of the reasons in favour of a fixed chronological retiring-age which might have been valid half a century ago are now invalid. Among these are some economic considerations, such as finding employment for the younger generation and that after a given age there is invariably, or at least in the majority of persons, so great a deterioration of physical and/or mental capacity as to make their employment unprofitable, and possibly hazardous to themselves and fellow workers.

There are certain drawbacks to the withdrawal of a fixed retirement age. Some of these are listed in the minority report of the conference convened by the McGregor Foundation (see above). The importance of these reasons must be weighed against the reasons in favour of flexibility. The administrative difficulties of a flexible policy, especially if applied to scientific, technical, and managerial personnel, can surely hardly be weighty enough to outweigh the advantages, especially where there is a clear shortage of such personnel and no reasonable probability of the position being much ameliorated in the foreseeable future. The import of the last statement can scarcely be ignored in South Africa, with its very rapid increase in the number of persons over 65, and with its special need to supply leadership for the advancement of the Africans.

It seems pertinent to close this memorandum by suggesting that Mr. John L. Springer's remark (see above) is a message South Africans may well ponder seriously: "We talk of educating our youngsters in science, but we neglect the obvious truth that a scientist in the hand is worth two in the cradle." And this applies not only to scientists.

It must be pointed out that this memorandum is not concerned with the many special problems which have to be faced in a discussion of national retirement or old-age pension schemes; the concern is solely with the presentation of available information bearing on the advisability or otherwise of retaining able-bodied persons in employment beyond the usual retiring-age, particularly of scientific and skilled workers, technologists, and clerical and administrative personnel; and whether there is a likelihood of there being a sufficient number of such persons in the population to make a policy of flexible retirement age worth while and beneficial.

I am grateful for the assistance given me by the United Kingdom and United States of America Information Services, the Information Section of the International Labour Office, the Royal Society of Medicine, and the Director of the South African Bureau of Census and Statistics.

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GENERAL-PRACTITIONER MATERNITY BEDS IN A LARGE GENERAL HOSPITAL

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General practitioners are most keen to practise the art of midwifery with full hospital facilities at their disposal. Great attention is paid to this matter at various meetings of general practitioners, and in particular at the Annual Representative Meetings of the British Medical Association, where resolutions are passed almost annually demanding access for general practitioners to midwifery beds in hospitals, with full co-operation from the other hospital departments. A scheme of this type has been started at Kingston Hospital; and here I give a report of the first thousand cases delivered by general practitioners, compared with 1,763 delivered in one year on the other side of the department.

Kingston Hospital is a large general hospital of 534 beds. There is a maternity unit of 99 beds, recognized by the Central Midwives' Board as a first-part training school, under the supervision of Mr. A. B. Stenhouse and myself. In 1953 we decided to give 11 beds for the use of 20 general practitioners in the Surbiton/Kingston area. The opportunity to allow general practitioners to work in the Kingston Hospital arose when 11 maternity beds in Surbiton Hospital had to be closed because of staffing difficulties. At this time the Surbiton maternity unit was staffed by a consultant and 20 general practitioners. I discussed the possibility of replacement of the 11 beds lost to the general practitioners at the Surbiton Hospital with beds in the large maternity unit at Kingston Hospital, and my colleagues and the other authorities agreed to this. There were, however, many difficulties to be overcome before the general practitioners' unit could start. The sisters were worried, at first, regarding how they could divide their time between the larger main part of the department and the general practitioners coming in at various times of the day to see their patients. In spite of this we started the experiment, and I am glad to say it has been a success.

Departmental Rules

Before we started this unit a subcommittee, consisting of consultants from Kingston Hospital and

representatives of the general practitioners who were going to use the unit, agreed to certain rules which were to be used in running the department. The rules, briefly, are as follows:

All patients must be seen by a consultant or senior registrar at, or about, the 36th week of pregnancy.

Should the pregnancy become abnormal, the patient becomes the joint responsibility of the consultant and the general practitioner. The general practitioner calls in the consultant when he deems it necessary.

All the doctors using these beds have access to all the departments in the hospital. They may, for example, have any pathological tests done in the laboratory, or have x-ray investigations carried out.

When the babies are born they are all examined by the paediatrician or his assistant, the general practitioner being present whenever he wishes.

All anaesthetics must be given by a member of the anaesthetics department of the hospital. We felt this to be essential because anaesthesia has proved to be, in my experience, the commonest cause of maternal death.

At the time of delivery the general practitioners can get any help they wish from the consultant or registrar, and they are encouraged to have one of the junior staff to assist at all operative deliveries.

The bookings are done by one of the senior sisters of the departments, and there has been no difficulty or argument so far. The patients are from the general practitioner N.H.S. List, and therefore the general practitioners charge no private fees but receive the normal N.H.S. allowance.

The general practitioners are satisfied with the system and it is continuing very happily up to date. It is not always possible for them to attend all deliveries booked by them in the unit, and when they are unable to be present one of the resident staff deputizes for them if required to do so. Otherwise the duty sister delivers the patient and reports to the general practitioner as soon as possible.

Mr. Roper, who has completed his term as senior registrar at Kingston Hospital, kindly analysed the first thousand deliveries in the general-practitioner unit of this hospital. For comparison, the total deliveries in the established unit of the hospital during the year 1956 have been analysed, and by comparing these two lists a rough idea of any variations can easily be gained.

General-practitioner-ward Statistics—Kingston Hospital

Total cases	1,000	Primigravidae	551 (55.1%)
		Multigravidae	449 (44.9%)
Total babies born	1,006		
Maternal deaths	Nil		
		No.	
1. Premature live births		16	
2. Neonatal deaths		3	
3. Stillbirths		12	
4. Notifiable pyrexia		30	(3%)
Genital causes		5	
Extragenital causes		25	
5. Caesarean section (all lower segment operations):		5	(0.5%)
6. Forceps delivery		84	(8.4%)
7. Post-partum haemorrhage (20 oz. (570 g.) or more)		84	(8.4%)
If defined as over 20 oz., number is		68	(6.8%)
(1 case of secondary P.P.H. is included.)			
P.P.H. cases receiving blood transfusion		10	
8. Manual removal of placenta		11	
9. Surgical induction of labour		76	(7.6%)
10. Toxaemias of late pregnancy		60	(6%)
11. Breech presentation		11	(1.1%)
Primigravidae		5	
(1 stillbirth, 1 neonatal death)			
Multigravidae		6	
(2 stillbirths)			
(This included one case of compound presentation with prolapse of the cord treated by internal version and breech extraction.)			

Kingston Hospital Maternity Unit—1956 Statistics

Total cases	1,763	Primigravidae	891 (51%)
		Multigravidae	872 (49%)
Maternal death (hyperemesis gravidarum)	1		
		No.	
1. Premature live births		65	
2. Total live births		1,720	
3. Stillbirths		44	(2.4%)
4. Neonatal deaths		30	(1.7%)
5. Notifiable pyrexia		102	(5.6%)
Genital causes		24	
Extragenital causes		78	
6. Caesarean section		33	(1.9%)
Lower segment		32	
Classical		1	
7. Forceps delivery		143	(8%)
8. Post-partum haemorrhage (20 oz. (570 g.) or more)		198	(11.2%)
If defined as over 20 oz. number is		169	
Blood transfusions		40	
Secondary P.P.H.		10	
9. Manual removal of placenta		27	(1.4%)
10. Surgical induction of labour		177	(10%)
11. Toxaemias of late pregnancy		201	
12. Eclampsia		1	
13. Breech deliveries		40	(2.2%)
Uncomplicated:			
Primigravidae		11	
Multigravidae		6	
(No stillbirths or neonatal deaths)			
Complicated:			
Primigravidae		11	
(4 stillbirths)			
Multigravidae		12	
(1 stillbirth, 2 neonatal deaths)			

There are several important points in favour of the B.M.A. policy of recommending the opening of a proportion of midwifery beds in general and maternity hospitals for the use of general practitioners. It allows the general practitioners to pick from their practices the patients they would like to deliver personally in hospital. They are looking after their patients in the best possible conditions with the same facilities that the consultants have. It keeps the general practitioners in constant touch with modern methods, and in my opinion reduces to a minimum the need for regular refresher courses.

In the Kingston area some of the general practitioners are former residents in the maternity department. They have recently passed the D.Obst.R.C.O.G. examination and are therefore especially suited to continue work in the hospitals.

The Kingston scheme has been very successful. I had fears of difficulties arising with the nursing staff and with bookings, but time has proved these fears needless.

A study of the short lists inserted above will show that the general-practitioner results compare most favourably with the work in the rest of the department. I would particularly like to point out that there was no increase in the amount of cross-infection and sepsis.

Following the success at Kingston Hospital, St. Teresa's Maternity Hospital in Wimbledon, which is a 62-bedded hospital, recently set aside nine beds for the use of general practitioners in the Wimbledon area. These have also proved most popular with the doctors and patients alike.

I would strongly recommend general and maternity hospitals throughout the country to follow our practice at Kingston in allowing general practitioners to use a proportion of their maternity beds along the lines suggested in this article.