Correspondence

Letters to the Editor should not exceed 500 words.

Emigration of Doctors

SIR,—Recent expressions of interest in the emigration of physicians from the United Kingdom have prompted me to forward the following information relating to the flow of British physicians to the United States and their activities in America. Some of these data have been published.^{1,2} Others have been collected recently in connexion with a more general study of the migrations of foreign physicians and medical scientists to the United States.

A definitive measurement of the emigration rate is not possible because the future movements of British-trained physicians in the United States cannot be predicted with certainty. Some British physicians who become U.S. citizens may later return to the United Kingdom, and an unpredictable number of "visitors" who never change citizenship may stay permanently in the United States, becoming *de facto* immigrants. Thus an individual cannot be conclusively identified as either a non-emigrant or an emigrant until he has completed his career. Nevertheless, the data below and those of Seale³ provide the basis of crude estimates of present rates of emigration.

There are now approximately 300 British biomedical research trainees in the United States.¹ Roughly 40% of them are physicians. The average duration of the visits of those who return is about two to three years. Therefore about 120 individuals from Great Britain begin research training each year in the United States. It seems likely that about 20% of the recent trainees from the United Kingdom will remain in the United States permanently.¹

In a 1963 sample survey¹ of roughly 6% (4,316) of all U.S. biomedical research workers we found that 71 were born in the United Kingdom. These and other related data suggest that there are about 1,000 British-born medical research workers in the United States, of whom about 400 are physicians. The great majority of these medical doctors have British degrees and roughly 150 are now U.S. citizens.

In the academic year of 1963–4 there were 149 residents and interns in U.S. hospitals who were graduates of medical schools in the U.K.² This number included only those who indicated that they were visitors and did not include an undetermined number of avowed immigrants. In addition there are an undetermined number of British "graduate trainees" in U.S. hospitals. Excluding research trainees this number probably does not exceed 25.

During a period of 6.5 years ending in 1962, 241 citizens of the U.K. who were graduates of British medical schools were granted waivers of their obligations to leave the United States relating to their visa status as exchange visitors. Thus about 35 to 40 per year who entered as visitors were granted

permission to stay indefinitely in the United States.

In 1963, 78 British graduates received licences to practise in the United States. A fraction of this group, about 20%, had previously received U.S. licences in other states and thus did not represent new additions to the profession.

Taking these data and these estimates into account, and in view of still other considerations, I estimate that about 80 British-trained medical doctors per year receive U.S. citizenship. But a substantial number of graduates of British medical schools seem likely to stay in the United States indefinitely, even though they have not and may not change their citizenship. And many of these, particularly those in academic positions, may not seek U.S. licence to practise. Therefore, in addition to a substantial number of non-physician medical research workers, roughly 120 British medical doctors per year are taking up permanent residence in the United States. These estimates confirm those recently suggested by Seale.³—I am, etc.,

KELLY M. WEST.

University of Oklahoma,
School of Medicine,
Oklahoma City, Oklahoma, U.S.A.

REFERENCES

- West, K. M., *J. med. Educ.*, 1964, **39**, 237.
- Nunemaker, J. C., Thompson, W. V., and Tracey, P., "Graduate Medical Education in the United States," from the *Directory of Approved Internships and Residencies*, Chicago, American Medical Association, 1964.
- Seale, J., *Brit. med. J.*, 1964, **1**, 1173.

Vaccination Against Whooping-cough

SIR,—Drs. N. R. Butler and P. F. Benson (27 March, p. 841) state that whooping-cough vaccine is contraindicated in children with a history of convulsions and in those who have had a systemic reaction to a previous immunization.

In "Any Questions?" on p. 845 your expert states that "it is generally agreed that it is unwise to give pertussis vaccine to a child with a history of convulsions." He says that "it is just such a child that is apt to have a reaction. It may be only a moderately severe local one, but occasionally it may be general and include an encephalopathy."

I am unaware of the evidence that these two statements are correct, and there is evidence to the contrary.¹

Fits in the first two or three months of life are due to a variety of causes, such as hypocalcaemia, hypoglycaemia, effects of delivery, and several other causes. I find it difficult to believe that the perivenous demyelination seen in encephalitis following immunization is more likely to occur after these widely different conditions in the newborn than with other children. On the other hand, there is

evidence that an abnormal brain is more likely than a normal brain to be damaged by anoxia and therefore is more likely than normal brains to be damaged by whooping-cough. One has to balance the risk of whooping-cough without immunization against the risk of encephalitis following immunization. It is not easy to arrive at the truth, because encephalitis following immunization is so rare. I do feel, however, that it is unwise to make dogmatic statements to the effect that children who have had fits should not be given whooping-cough immunization. I would certainly have thought that it was most unlikely that a child who has had fits would be more likely to have a severe local reaction than others. I can't see any reason why he should. Yet this is what your expert states. It certainly does not correspond with my own experience of many thousands of immunizations. It has long been my practice to give the triple vaccine to infants who have had fits, and I have not had any trouble so far.

This is clearly a difficult and yet important matter. I would very much like to hear about the experience of other readers in this matter.—I am, etc.,

R. S. ILLINGWORTH.

The Children's Hospital,
Sheffield 10.

REFERENCE

- Melin, K. A., *J. Pediatr.*, 1953, **43**, 652.

The Catarrhal Child

SIR,—Mr. David M. Stevens in his letter (3 April, p. 926) in discussing "The Catarrhal Child" points out the lack of emphasis given by Dr. D. H. Garrow (20 March, p. 773) to the association of deafness and "catarrh" in childhood.

It is my belief that recently there has been a marked increase in the number of children coming to ear, nose, and throat out-patients where the main complaint has been of deafness. Clinical impressions are notoriously false. I have therefore reviewed the case histories of some children who have had their tonsils and adenoids or just adenoids removed in Leeds. In the six-month period April to September, 1959, 1,139 cases were operated on. In the same period of 1962 there were 900 cases and in 1964, 1,032 cases. It is very revealing and in fact quite alarming to count the number of myringotomies performed on these cases. In 1959 out of over 1,000 cases paracentesis tympani was performed on three children. In one case no fluid was found. In 1962 26 myringotomies produced fluid in 20 cases in one or both ears. However, in the six-month period of 1964 when 1,032 cases were operated on no fewer than 130 myringotomies were performed, fluid being found in one or both ears in 106 cases.

There may be many reasons for this enormous increase in the number of deaf children. I am sure all otologists are more aware of the condition and in consequence are looking out for it. However, I am equally sure this does not account for such a phenomenal rise in five