LETTERS TO THE EDITOR

AUTHOR'S POST

Rejection Slip Dejection Blues

SIR — The following editorial rejection note represents assuredly the ultimate in oriental courtly manners and diplomatic face-savers.

"We have read your manuscript with boundless delight. If we were to publish your paper it would be impossible for us to publish any work of a lower standard. And as it is unthinkable that, in the next thousand years, we shall see its equal, we are, to our regret, compelled to return your divine composition, and to beg you a thousand times to overlook our short sight and timidity."

I am, etc.

E E VELLA

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24 August 1981.

REFERENCE


WHITHER THE RMO

SIR — Very recent experience in a BAOR Armoured Division leads me to question the assumption on which your recent editorial1 and the letter from Capt T P Finnegar2 was based. Far from having ‘virtually disappeared’ I am glad to reassure you that the Regimental Medical Officer (RMO) is alive and well. Indeed a recommendation of a BAOR work study group to adopt a ‘medical group system’ at the expense of the RMO met with unanimous opposition among my medical officers, and I am pleased to report was not pursued.

Virtually all my RMOs proudly wore the insignia of their regiments and were deeply involved with them. As Manning improved more time became available for other than clinical duties and was eagerly taken up. Irrespective of time available, however, it was my impression that RMOs were very well aware of environmental factors within their regiments since this was equally important from the viewpoint of general practice as from preventive medicine and thus formed an essential part of their vocational training. Of course, the balance has changed from that called for in the ‘Classic RMO post’ (whatever that was?), but I suggest the change is for the better. Undoubtedly the job has been enhanced by vocational training which was reduced professional isolation, increased clinical skills and enormously promoted job satisfaction.

The degree of involvement in the Military elements of the RMO’s task only partially depends upon time available. Much also depends upon the individual,
his background, interests and experience. Where experience is lacking, as is often the case, then encouragement, support and training must be available from the unit and more particularly from the formation medical staff. There is a need to be available as professionally and enthusiastically as is clinical support from general practitioner trainers.

I am, etc.

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24 August 1981

REFERENCES

WHITHER THE MEDICAL OFFICER

SIR — Maj Lillywhite has, we suspect, been deliberately provocative in his letter (J R Army Med Corps 1981; 127: 155-6). He has enlarged the discussion of the role of the RMO to include the role of the doctor in the army.

Doctors have always professed that their first loyalty is to their patients. We detect little evidence that this loyalty is any less today than it ever has been. Soldiers are more affluent than they were two generations ago and in a small regular and relatively static army, most live with their wives and children whom the army doctor will also recognise as his patients. The Royal Colleges go to a great deal of trouble to ensure that postgraduate training in all the branches of medicine ensures a uniformly high standard of medical practice in the United Kingdom. The standard of training and practice of the army doctor cannot be allowed to fall below the national norm. The insistence of the Royal Colleges on structured postgraduate training has undoubtedly increased the number of doctors needed in a given community, and this has exacerbated the short-fall of medical officers in the army over the past 20 years.

The evidence of basic research that Maj Lillywhite fails to see is to be found in a number of papers and reports that are perhaps not widely available. Very few medical officers have the aptitude for basic research, and the few that have normally find means of pursuing it. Many more medical officers will have the aptitude for and interest in applied research into military medical problems. The recent organisation of the Army Medical Research Committee and its off-shoot the Army Medical Research Executive will improve the opportunities for medical officers to become involved in applied research. Effective applied research costs money in terms of time, facilities and equipment. The need for more and better research has been expressed not only by senior medical officers of the army but also by the civilian consultant advisers. Maj Lillywhite possibly does not appreciate that by the very nature of things there must be a
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considerable time gap between the conclusions from basic research and their application in doctrine and training.

As an example of the difficulties we would cite his statement on the causes and prevention of acute respiratory distress found in armoured warfare. Having studied this problem for almost 10 years we are aware that the answer must come from a vast and expensive programme of basic and applied research. It would be quite wrong and a dis-service to the soldier to give a facile answer to this question at the present time. On the other hand the development of plastic spectacle lenses would, one imagines, be a fairly simple matter. In this as in many other matters in which the Medical Services are peripherally involved the protection of the soldier is a matter for the military commander who can define it in terms of an operational requirement.

We can assure Maj Lillywhite that the most senior doctors in the Army Medical Services have given considerable thought to the problems resulting from chemical warfare and they have stimulated the responsible Agencies to pursue research designed to minimise casualties from chemical warfare agents and to improve the quality of care for battlefield casualties. Much work remains to be done but there is an increasing enthusiasm from Regular and Reserve medical officers for this important field of preventive and curative military medicine.

Maj Lillywhite is quite right to exhort us to prepare and train for our wartime role. Most Regular army medical officers are fully committed in the prevention or in the treatment of illness and injury. There is, therefore, an added responsibility on those of us not so completely committed to take up the challenge for preparing for the future by the encouragement of research and the education and training of Regular and Reserve medical officers. Col Peter Abraham (J R Army Med Corps 1981; 127: 115-121) has described the College response to this challenge and we associate ourselves entirely with his views.

We are, etc,

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12 November 1981

GURKHA OBSTETRICS

SIR — I welcome the comments and criticisms made by Cols Padgett and Walters, and concede that the omission of birth weights in the article was an error on my part. However, it was intended to provide a general discussion on the problems of Gurkha Obstetrics in Hong Kong, as well as looking at perinatal mortality in particular. The article does appear to have stimulated some discussion about improvements in maternity and neonatal services for Gurkhas in Hong Kong. It must be hoped that this discussion can be turned into action.
On another tack, a comment is made in The Lancet (September 19) about 'Militant Antenatal Care'. The writer implies that the attitude taken is unnecessary. He is perhaps not unaware of many of the facts — some of which I tried to bring out in the article — which make Gurkha antenatal care vastly different from that of British soldiers’ wives.

The two groups of women are worlds apart geographically and culturally. All Gurkhas are used to 'taking orders', the men from their officers and, of course, in a different fashion, the Gurkha wives from their husbands.

The importance of good antenatal care is made clear to the Gurkha soldiers. The wives, in many instances, are unable to appreciate its value. It is therefore the soldiers who help to ensure that their wives attend regular antenatal clinics. I hope that this helps to clarify matters.

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GURKHA OBSTETRICS AND PERINATAL MORTALITY

SIR — The article on Gurkha obstetrics and perinatal mortality by Rasor1 recently published in this Journal has given rise to a minor flurry of correspondence2-5. This is welcome as it indicates in the most positive way that such articles are not only read but that they move people to comment upon them, and often in a provocative fashion.

Several issues are raised, some of which appear to call for comment. Of these the question of the comparison of crude perinatal mortality rates in a single area over a period of three and a half years is perhaps the most important. Rasor1 quotes a figure of 21.5 and Padgett and Walters5 one of 15.9, apparently a dramatic and most welcome reduction. While such an improvement should be anticipated in any progressive medical service the actual numbers involved are relatively small, Rasor reports 15 deaths in 698 births over a nine month period and Padgett and Walters 19 deaths in 1189 births in two years. The probability of this difference arising by chance is 0.4 and time alone will reveal the true degree of improvement.

However tests of statistical significance are just that, a mathematical evaluation. It would be surprising if there were not some steady improvement, and the very fact that a special care baby unit was established in Hong Kong in 1979, the first year to which Padgett and Walters refer, could be expected to be reflected in the figures.

There are no grounds for complacency, even if the most recent Hong Kong rate is identical to that reported in Northallerton in 1975-78 by Wain4 for the
total population, and appreciably better than for the Service rate she reports as 26.1 per thousand. Her figures are disturbing, the more so as Army experience in BAOR, an area in which we are almost totally responsible for medical care, have remained at least as good as those of the UK as a whole.

Finally, there is the question of "militant antenatal care". Lewis provided an admirable reply. There are inevitably some profound differences between military and civil practice, not limited to the medical field, and these may be even more apparent when a different culture from that using the NHS is involved.

I venture to think that there are many involved with antenatal care in the UK who would welcome some form of sanctions, even if they were tacitly acknowledged to contain a large element of bluff, to achieve early booking and regular attendance. Is this so very different to the Finnish system whereby the phased financial benefits are linked to regular attendance at antenatal clinics?

Wain may well have written her letter before reading that of Lewis but her reference to "draconian measures" and "harsh disciplinary action" are rather emotive. Her findings are a justification for early and regular antenatal care, and perhaps for much else, and the measures taken by the Army are not as oppressive as they read in cold print!

I am, etc.

D E WORSLEY

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REFERENCES


