

ing a satisfactory radiological examination takes priority, and the reports are dictated after that.

The response of the medical students is tremendous. Recently, in the second year, a request for more instruction in the radiology of the chest brought 90% of a class of 100 back at 7 p.m. to the medical school, where they stayed until 10 p.m. They would have gone on if I had not cried a halt in self-defence. There are, during teaching sessions, as many as six radiologists in the medical school at one time, teaching groups of 12 or 15 students for an hour or two everything that can be learned from normal and then, subsequently, abnormal radiographs.

Dr. Bull delivered the message very clearly: the average doctor will use radiology for the whole of his medical career. The proper persons to teach this subject are the radiologists, and the more they are asked to help, the more interested and responsive they become. Everyone benefits, not least the radiologist. It is still the widest "general practice" left to anyone in medicine, because all specialties need the help of a radiologist. His interests are wide and can lead him where he wishes. But regard the radiologist as a technician, give him poor facilities and too much work, and it is not surprising that Britain, with so much to offer in clinical radiology, is desperately short of radiologists.—I am, etc.,

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SIR,—The article by Dr. J. W. D. Bull (10 August, p. 394) once again highlights the dilemma of diagnostic radiology in clinical medicine in the British Isles. It is not enough that radiologists could or should take part in teaching students anatomy, pathology, physiology, or the clinical subjects. It is time that radiology was included in the curriculum of the medical schools as a recognized essential with a formal course of instruction and an examination in the final M.B. Whether clinicians wish to admit it or not radiology is now at the centre of clinical diagnosis. There is therefore no good reason why radiodiagnosis should not be included in the undergraduate medical curriculum, perhaps replacing some of the more exotic subjects.

In many instances radiographers are used to teach clinical medicine, often by clinicians whose knowledge of radiology leaves much to be desired. Enlightened physicians and surgeons everywhere recognize their duties to students to teach clinical methods. It is a sad fact, however, that the art of clinical medicine today leans too heavily on ancillary diagnostics. The clinician demonstrating radiographs to students on a ward round is an all-too-common occurrence and a worthless exercise. Similarly the use of radiographs by clinicians when examining in the higher examinations is to be deplored.

Diagnostic radiology has much to offer and much to contribute to medicine, but so long as radiologists allow themselves to be treated as second-class doctors the future of radiology as a discipline is bleak, recruitment will remain difficult, the shortage will continue, and emigration to countries where

as an equal by his clinical colleagues will undoubtedly increase.—I am, etc.,

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Antenatal Battering

SIR,—At a recently held case conference plans were discussed on the management of a baby who will be at risk from battering. At that meeting the child in question was in utero at a maturity of 38 weeks by dates. At 32 weeks the mother had, during an acute anxiety state, threatened the fetus with a large knife brandished over her gravid abdomen. She was diagnosed as having hebephrenic schizophrenia 12 years ago and had had fears of murder and baby battering even before marriage. With such a history we felt that all efforts should be made to prevent the possibility of injury to this, her second child.

Baby battering situations have usually been discussed after the birth of the baby and these discussions may be too late in some cases to prevent disaster. We feel that the antenatal period has been neglected at a time to assess the risk factors for the baby and that such assessment may be ideal in some cases for action to be taken at the very earliest opportunity and avoid calamity.—We are, etc.,

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Deaths during Dentistry

SIR,—Dr. J. G. Bourne (16 November, p. 408) states that at the inquest on a 13-year-old boy arising out of death during a dental anaesthetic the anaesthetist, the pathologist, and he himself were all agreed that the death was almost certainly due to fainting. Perhaps these extracts from the details supplied to me by the coroner might clarify the issue.

Pathologist's report: External appearances "cyanosed"; brain "congested"; respiratory system, "lungs congested, red, oedematous, larynx and trachea very congested, marked pharyngitis"; and after reviewing the histology—"the findings are those of an acute asphyxial death in a boy who shows abnormal adrenal hypoplasia and an acute upper respiratory infection." The coroner's summary after hearing all the evidence was that this was an "asphyxial type death following cardiac arrest during an anaesthetic of nitrous oxide, oxygen, and halothane."

These observations would seem to differ from those contained in Dr. Bourne's letter. I did consider the interpretations offered at that inquest. In this I was following Dr. Bourne's own advice¹ in viewing the expert as not always being informed and impartial, and so preferred to stick to the evidence of fact and to ignore that of opinion.

This child died during the recovery period of the anaesthetic, and this is not uncommon among dental anaesthetic deaths. If the explanation for these deaths is fainting could Dr. Bourne explain how it is possible to faint while anaesthetized or recovering from an anaesthetic? What causative mechanism

or neurophysiology does he postulate? Why does vagal escape not occur? Since the venous return and output of the right ventricle are more than adequate to pump blood into the lungs, is he suggesting that the "fainting" of dental anaesthesia selectively effects only the left ventricle? The peripheral vasodilatation that occurs in the common faint is presumably of little consequence in the dental anaesthetic situation in view of this high venous return. If so, we are dealing with a unique type of "faint" and perhaps this label should be abandoned. This is of some importance since part of the treatment of the common faint is to augment the venous return and this could possibly jeopardize what little chance the patient has of surviving. Retaining the label "fainting" could thus cause dangerous confusion.

However, this argument is a distracting side issue from the main message of my letter, which was a condemnation of the practice of an operator anaesthetist for prolonged anaesthesia and a call for pressure to have this practice discontinued.—I am, etc.,

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¹ Bourne, J. G., *British Medical Journal*, 1973, 1, 293.

SIR,—The report of your legal correspondent (9 November, p. 352) is a tragic story. I would like to draw attention to one sentence in the evidence which I feel may have considerable significance and which appears to have passed without comment.

The dental surgery assistant in her evidence said "she thought that [the patient] was a pale colour *at the start*" (my italics). As I have previously pointed out (27 July, p. 258), "pale and frightened patients are very special risk patients who need extra care in their management." There are many anaesthetists who would not think that the technique employed in this case was ever justifiable, but I suggest that insufficient emphasis is currently being made on the need to treat pale, frightened patients as special risk cases.—I am, etc.,

E. O. EVANS

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SIR,—For many years Dr. J. G. Bourne has emphasized the dangers of fainting in the upright position during the administration of general anaesthesia for dentistry. It seems that the importance of Dr. Bourne's observations is very much understressed.

The fainting phenomenon during induction is rarely seen by hospital anaesthetists in their routine work, probably because: (1) most inductions take place on supine patients; (2) many patients are sedated by pre-medication, making the psychogenic faint unlikely; and (3) full-time anaesthetists are usually quick and efficient at venepuncture.

In contrast in the dental surgery often these three factors do not apply. Personally, I have witnessed several instances of psychogenic fainting in the dental chair in the upright position (fortunately corrective action was taken on each occasion). In most of these cases the trigger factor was repeated attempts at venepuncture.