visory function. Such a body is a most inappropriate one for a health authority to turn to for advice on the financial and clinical implications of diagnostic radiology in current hospital medicine. There is no reason to think that the situation is different in other regions, and diagnostic radiologists would do well to take heed of the action of their colleagues in Wessex.

The question of a radiographic advisory body at regional or, indeed, any other level in the reorganized advisory structure is a related yet separate issue which has not yet been discussed by our committee. It might most satisfactorily be solved by consultation between the appropriate radiographic and radiological professional bodies. However, if the Wessex and East Anglian pattern was to be followed nationally radiographers might feel their interests could with advantage be voiced by close liaison with and representation on such radiological advisory committees rather than relying only on regional scientific committees.—I am, etc.,

G. I. VERNEY
Chairman,
East Anglian Regional Radiological Advisory Committee
Addenbrooke's Hospital,
Cambridge

1 *Report of the Committee on Hospital Scientific and Technical Services*, 1968. London, H.M.S.O.

Ethics and Halothane

SIR,—Anaesthetists have been placed in a difficult position when they are required to administer repeated anaesthetics for relatively minor procedures. They are well aware that no method of anaesthesia is absolutely safe and every technique of rendering a patient unconscious for surgery involves a definite though, happily, a small risk to life. Their task is to balance the hazards of different techniques and to choose that which seems the safest and most suitable, having regard to the nature of the operation and the state of the patient.

Of the various risks which are inherent in anaesthesia, that of postoperative hepatic dysfunction has now received a great deal of attention from specialists outside anaesthesia. The majority of anaesthetists have never encountered a case of postoperative jaundice which could reasonably be attributed to their anaesthetic, though they have had experience of many other much commoner complications of anaesthesia. Most of these have entirely escaped the attention of non-anaesthetists and have not been the subject of notices from the Committee on Safety of Medicines. The anaesthetist's judgement of the relative risks may be distorted from fear of litigation and he may resort to other techniques which are inherently more dangerous but about which the documentation is less readily available for the purpose of bringing an action for negligence.

Selection of an alternative to halothane may present difficulties. Sometimes it is possible to use regional analgesia, but there are plenty of cases where this is not feasible and the patient must be made unconscious. Drugs such as ketamine, anaesthetic steroids, and barbiturates and the technique of neuroleptanalgesia have a limited place, but there remain many patients who require inhalational anaesthesia. Dr. J. M. K. Spalding, in his second letter (9 November, p. 345) states his opinion that, if patients receive a non-halothane anaesthetic, they will not be exposed to the danger of postoperative hepatic dysfunction as they would be if they received halothane. Regrettably this is not true. The National Halothane Study[1] showed that postoperative hepatic necrosis occurred in substantially the same proportion of patients after several different anaesthetics. Case reports also give no reassurance that safety can be guaranteed by avoiding halothane. One patient died in the series which Lindenbaum and Leifer[2] reported under the title "Hepatic Necrosis Associated with Halothane Anaesthesia." That patient died after a second anaesthetic, the first with halothane, the second with methoxyflurane. In similar vein, Klein and Jeffries[3] reported a patient who was anaesthetized with thiopentone and cyclopropane and, two weeks later, with thiopentone and methoxyflurane. Early postoperative hepatic dysfunction followed the second anaesthetic. The evidence of these three publications gives us no confidence in the belief that postoperative jaundice can be avoided simply by substituting another anaesthetic for halothane.

The crucial problem at present is that we do not know what is the cause of postoperative hepatic dysfunction in these cases. It may be due to halothane itself, but the evidence outlined above suggests that it may be a response to general anaesthesia induced with any agent, or to the operation undertaken. If that is so, then there is no reason to discard halothane, which has proved so successful throughout the world during the past 17 years. It is of great practical importance to discover whether the substitution of another anaesthetic for halothane does or does not reduce the risk of postoperative hepatic dysfunction. Clearly the answer must be sought in prospective clinical trials as outlined in the statement of the Medical Research Council[4] and supported by your leading article (7 September, p. 589).—We are, etc.,

J. F. NUNN
A. J. COLEMAN
H. T. DAVENPORT
G. H. HULANDS
J. G. JONES
R. S. CORMACK
Division of Anaesthesia,
Clinical Research Centre,
Harrow, Middlesex

1 National Halothane Study, *Journal of the American Medical Association*, 1966, **197**, 775.
2 Lindenbaum, J., and Leifer, E., *New England Journal of Medicine*, 1963, **268**, 525.
3 Klein, N. C., and Jeffries, H. G., *Journal of the American Medical Journal*, 1966, **197**, 1037.
4 *British Medical Journal*, 1974, **3**, 268.

Genitourinary Medicine

SIR,—The decision by the Department of Health and Social Security and the Royal College of Physicians, seemingly mesmerized by a miniscule minority opinion, that the word "venereology" be virtually expunged from medical terminology (leading article, 11 January, p. 51) betrays an astonishing lack of appreciation concerning the function of venereologists and their clinics, a nineteenth-century concept of adult sexual psychology, a touching but naive reliance on the ability of euphemisms to alter attitudes, and finally an obdurate disregard for the opinions and desires of the country's practising venereologists who, at a fairly recent meeting of the Medical Society for the Study of Venereal Diseases, debated and rejected the term "genitourinary medicine" and subsequently, by referendum, voted for "no change" in nomenclature.

While much clinical material involves the urogenital apparatus of the two sexes, this can be managed by medical assistants, but all who work in venereal diseases clinics, special treatment centres, departments of sexually transmitted(?) diseases, call them what you will, know that the consultant venereologist's ambit is not limited by considerations of anatomy. Those who do not work in these clinics have only to glance at the list of contents and chapter headings of *Recent Advances in Venereology* to realize the truth of this assertion. I have sought to show elsewhere[1] that over 60% of the venereologist's function as a consultant is quite unrelated to the genitourinary system. What of the treponematoses? Indifference to the relatively few demands these make on our professional expertise in the United Kingdom is utterly parochial.

We are too concerned not only with the widest of clinical and anatomical horizons but also with the bacteriology, serology, and epidemiology of the world's greatest man-made pestilence, known as *le péril venerien* to the French, to style ourselves genitourinary physicians. These are the aspects of the scene which justify our existence as a separate discipline, which necessitate special clinics and all their laboratory appurtenances, their social units, their contact tracing, and their submission of statistical returns, etc. Despite numbers, the diagnosis of genitourinary cases in particular and treatment in general are the least of our problems. It is clearly in the realms of behavioural science that any hope for the future may be placed.

With new registrations having risen from 90 000 to 360 000 in less than a quarter of a century (enough, surely, without seeking to trespass on the domain of nephologists, gynaecologists, and genitourinary surgeons?) our latter day, adult, sophisticated, and educated society, albeit sadly lacking in sex education, shows precious little aversion to attending the clinics, where fear and shame are or should be dispelled by the ministrations of the staff rather than swept under the carpet by the crazy cult of not calling a spade a spade. Those thus afflicted are too few to warrant changing the name of our time-honoured and long-fought-for specialty. A person with a venereal disease insists on being treated by a specialist in his disease, a person free from "V.D." is glad that a specialist in this subject tells him so, while those who are ignorant of the nature of the clinic that they attend are not long in acquainting themselves with its true purpose. In this context even the all-embracing term "sexually transmitted diseases" is rapidly acquiring the same unhappy connotation as the word "venereal". No wonder! It means the same thing. The phrase "sexually transmissible" or "related" or "associated" would have been less psychologically and domestically traumatic and more accurate.

Let us be free to choose our euphemisms for designating the actual buildings we work in, if only out of respect for the susceptibilities of the public. But let no young registrar think his career will be more worthy or absorbing by having one vista of his already broad horizon further expanded beyond its proper domain or, more probably, having the whole concept ultimately narrowed by this bowdlerization. Nor should he feel more welcome in our midst by joining those who eschew our traditional appellation, common English usage, and simplicity of language.

The greatest danger in hiding our colourful identity under the dreary cloak of a terminological inexactitude—in this context a preferable term to "lie"—is that future genitourinary physicians will delegate the humdrum V.D. side of their work to others or make it second string to their bow, as was almost universal before the second world war.

If the word "venereology," as apt as any other "-ology," had never evolved through the centuries from Venus, venery, and venereal it would most assuredly have been

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