Correspondence

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Active Labour

SIR,—It would be beneficial to countless numbers of mothers and their infants if every medical student during his time in the labour wards and every specialist in training read the excellent, practical, and critical report on the prevention of long labour by the Master of the National Maternity Hospital and his team (24 May, p. 477).

There is one useful addition to "formal rounds of the delivery units at regular intervals every day, and especially late at night." It is the constant presence of a senior person of at least registrar or lecturer status in the labour ward suite on a rota system 24 hours a day in every major obstetric unit. The definition of "major" is outside the scope of this letter, but it could be suggested that no unit would be a major one unless this condition were fulfilled.

The implementation of this carries important implications. Adequate, preferably attractive, accommodation for resting and study with shower or bathroom and lavatory facilities must be built within the labour suite precinct. There should also be a seminar room, with current journals, teaching models, and possibly even television, where students and resident staff will be encouraged to meet

and to wait in at least reasonable comfort at any time of the night or day. They and the registrar on duty are thus encouraged to have the mutual benefit of discussions and tutorials on current problems in the labour ward. The provision of this accommodation is a matter for planning teams, but is too often forgotten, and is a main reason why the supervision of labour wards is sometimes not as good as it should be.

Dr. K. O'Driscoll's condemnation of the excessive use of analgesic drugs is important and timely. The use of caudal analgesia under the conditions he advocates of labour control would reduce to a minimum the need for any analgesic preparations. Moreover, the widespread use of a caudal (administered by the resident obstetric staff) introduces peace into a labour ward, still further shortens the duration of labour, and adds to the ease and safety of delivery in difficult cases. The increase in the incidence of assisted delivery is a small price to pay for the benefits received.—I am, etc.,

JOHN STALLWORTHY.

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and Gynaecology,
Radcliffe Infirmary,
Oxford.

Clinical Teaching at Cambridge

SIR,—Your leading article on clinical teaching at Cambridge (17 May, p. 395) was a clear exposition of the situation. Any objections to a clinical school by members of the Regent House could, however, be easily dealt with by administrative flexibility.

The university affirms the principle of equality of prime stipend, yet does not prevent its officers being paid for consulting and other work by outside bodies. Is the Cambridge Clinical School to founder because some means cannot be found to pay

for clinical responsibility in Cambridge, other than through the University Grants Committee? It seems very likely that it might.

Fears have been expressed that a clinical school might monopolize university funds to the exclusion of other developments. A block grant from the Treasury for a limited span would solve this.

The most important and only other serious objection to the development of a clinical school might be on academic grounds. The quality of clinical staff, the existence of pre-

clinical and postgraduate schools, the association with other scientific disciplines, and the abundance and variety of clinical material answer this objection quite clearly. Administrative flexibility will enable the birth of a clinical school, administrative rigidity will prevent it.—I am, etc.,

G. A. GRESHAM.

Department of Pathology,
University of Cambridge.

Methohexitone in Dentistry

SIR,—Professor John Robinson and his colleagues suggest (31 May, p. 540), and you repeat the allegation in your leader (p. 525), that the deaths associated with the methohexitone technique that have been reported in the press may well have been due to the effects they observed.

I question this, and doubt in fact whether there has been a single death genuinely attributable to the technique. Three years ago I analysed¹ 37 deaths with dental anaesthetics, one of which was with methohexitone, but probably not attributable to it. Since then there have been 13 further deaths reported in the press, of which four were with methohexitone. Two are irrelevant: a young woman ruptured a cerebral aneurysm after recovering from the anaesthetic (she had also had local anaesthetic with nor-adrenaline); a child, aged 7, had been given pentobarbitone and pethidine intravenously just prior to the methohexitone. The remaining two were as follows:

Case 1.—A healthy but extremely nervous girl, aged 14, was anaesthetized sitting up by a consultant anaesthetist for the extraction of two teeth. She was given methohexitone 50 mg. into a vein in the hand and instantly collapsed. She was given external cardiac massage and endotracheal oxygen, but without success. At necropsy, no abnormality was found and no cause for death.

Case 2.—A pale, nervous, but healthy young man was anaesthetized sitting up and then tilted

to an angle of 45° for conservations under further increments of methohexitone. His pallor increased. At 15 minutes he was noticed to be "pale-yellowish" and collapsed. Resuscitation restored the blood pressure, but he remained unconscious, developed convulsions, and died four days later, the brain showing extensive ischaemic necrosis.

Elsewhere,^{2,3} two cases of collapse, identical to that seen in Case 1, have been reported in young, healthy men given methohexitone sitting up in the dental chair. In each case the collapse occurred while the barbiturate was being injected, in one case when only 20 mg. had been given. Both patients were treated for cardiac arrest and recovered. And recently three dentists have each told me of young healthy patients who collapsed after the injection of local anaesthetic. Each patient suddenly became ashen, unconscious, apnoeic, pulseless, and had dilated pupils. They were treated for cardiac arrest and recovered, though one of them remained unconscious several hours. I have numerous records also of similar collapse, both fatal and non-fatal, with inhalational anaesthetics. In most, perhaps all, these cases the collapse

was probably due to an ordinary fainting attack,⁴ and we should blame not the anaesthetic but the upright or semi-upright position of the patient. Fainting can occur lying down, but in this position it is rare and probably never fatal.

Professor Robinson and his colleagues have used laboratory measurement; but surely there is room also for clinical judgement. Clinically the methohexitone method seems to me remarkably safe, and I shall continue to use it. But I agree with Professor Robinson that it has been abused. I have always thought, and he has now made it very clear, that the method should be reserved for dentistry that is neither difficult nor prolonged, with a limit of, say, 10 minutes for extractions or 20 minutes for conservations—and the patients should be lying down.—I am, etc.,

Salisbury, Wilts.

J. G. BOURNE.

REFERENCES

- ¹ Bourne, J. G., *Lancet*, 1966, 1, 879.
- ² Attwood, A. D., *British Dental Journal*, 1964, 117, 4.
- ³ Williams, C. G., *British Dental Journal*, 1964, 117, 123.
- ⁴ Bourne, J. G., *Lancet*, 1957, 2, 499.

Medicine and the Mass Media

SIR,—Whether we like it or not—and most of us don't—medicine is news. Our privacy, jealously defended for millennia, is now being invaded by the mass media for the information and entertainment of the public. The hospital or consulting-room will never again be an inviolable sanctuary. Times have changed, and in the interests of our patients and ourselves we must accept this intrusion and turn it to the benefit of all concerned.

A year and a half ago I expressed certain opinions about the medical, scientific, ethical, and financial aspects of cardiac transplants.¹ It is unfortunate that the questions I and others raised at that time were not fully aired within the profession and policies formulated then to meet the exigencies which were expected to arise. Had this been done, Fleet Street's coverage of the Sinsbury case would have been very different; there would have been no need for the Government to appoint a committee whose composition and deliberations are, up to the present, secret; and public opinion would not be in the state of furore it is today. The lack of kidney donors is a regrettable consequence of the mishandling on all sides of the heart transplant question. The change of emphasis in the controversy is mainly due to the attitude of the mass media. Having finally milked all the news value out of the recipients, they have now turned to the donor for new and emotive stories. This has seriously damaged the relationship between the profession and the public, and we have only ourselves to blame.

The public is bewildered and worried by what appear to be inconsistent reports about death and when death occurs. The layman is confused as to the role of the respirator in this respect, as well as to the significance of an E.E.G. in certain circumstances. He wonders why no E.E.G. was taken of the fatally injured nurse.

To relieve public fears and restore confidence we have to be much more frank. We must explain that death, like any other diagnosis, is based on clinical judgement. It is

a deduction made from a combination of present observations, past experience, and ancillary aids. Legal guidelines would be of little help. Similarly, when to switch off a respirator is not a more difficult clinical judgement to make than, for example, to decide the optimal moment to operate on an emergency admission diagnosed as an "acute abdomen."

The mass media should help us to instruct and inform the public properly. But for this we must be prepared to co-operate with them. The present controversy stems from our failure to conduct with dignity and common sense our relations with the press. Thus, they either get news from an enthusiastic exhibitionist or they have to drag it piecemeal out of us, and neither way serves the best interests of the profession or the proper enlightenment of the man in the street.

To begin with, when future heart transplants are done a comprehensive and comprehensible report should be ready for release as a single bulletin at any given moment. This would satisfy press and public alike, and also make us think twice before embarking on the procedure. We have to draw a distinction between confidentiality, which should never be broken, and secrecy, which in today's world is no longer practicable. In return for this sort of co-operation we could expect the press to underplay sensationalism and refrain from quoting us out of context. As for radio and television, if they really want to serve the public properly they should take time to prepare their interviews; and we should give them that time. The present "off-the-cuff" interviewing techniques are designed to create controversy by putting a man on the spot. This may be justifiable for politicians, since their stock-in-trade is a snappy catch answer, and whether it is true or not is of secondary importance; but it won't do for doctors.

The time is long overdue for a dialogue between ourselves and the editors of the mass media to establish a policy regarding the release and publication of medical matters in

general. The present "hit-and-run" relationship between ourselves and the press must stop. And the medical profession must take the initiative.—I am, etc.,

PETER BEACONSFIELD.

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London N.1.

REFERENCE

- ¹ Beaconsfield, P., *New Scientist*, 1968, 37, 125.

** Just after going to press the membership of the Government committee was announced.—ED., *B.M.J.*

Transplant Controversy

SIR,—I note there is the strong possibility of new legislation on the subject of organ transplantation, and in particular the question of the point of death.

Surely this is a matter for the clinical judgement of the doctor involved, aided by all the available scientific apparatus. It is for doctors themselves to work out acceptable procedural methods to make it abundantly clear to all concerned that every effort is always made to save life. I am sure the general public trust their doctors and realize the whole of our training imbues us with this life-saving purpose. It is undue reticence and reluctance to reveal the facts which breed suspicion.

As a general practitioner I take pleasure in the spectacular advances in heart transplantation, but regard it in the light of sending a man to the moon at huge expense while there are a multitude of earthly problems that cry out for urgent solution, at less expense, out of our already too limited budget.

Kidney transplants seem to be the urgent need of the moment, when so many young patients die who might be saved.

Many of our patients donate their bodies for medical research but usually die full of years or after debilitating disease. We are going to get votes at 18 years and permission to marry at 18. Could not every 18-year-old be asked whether he would be willing to allow his organs to be used for transplant if the unfortunate occasion arose? All the "noes" could be fed into a computer and surgeons could have quick access to the answers. This solution would provide many more donors and take the heat out of the question and avoid the tension and publicity associated with "shot-gun" consents.

Again as a general practitioner I feel we do too little to prevent the onset of heart and kidney disease and so avoid some of the expensive solutions necessary for established diseases.

This country suffers from far too much legislation. We don't wish to see the issue of a death certificate as a possible new cause for legal wrangle.—I am, etc.,

South Shields,
Durham.

JOHN MCKEE.

SIR,—Once again Professor Roy Calne (31 May, p. 565) complains that he and his fellow transplant enthusiasts are getting a raw deal and wants the law changed.

Professor Calne is, I believe, the only British surgeon to have done liver transplants. In any patient with liver disease who