departments, but I am convinced that the practitioner's decision to ask for an *x*-ray is often influenced by medicolegal considerations. Failure to order an *x*-ray examination is a well-known ground for a charge of negligence and the Union deals with a number of claims of this sort every year.

Unfortunately, the courts have tended to assume that if the patient has an undiagnosed fracture and no radiological examination has been carried out the medical attendant is *ipso facto* negligent. It is essential, of course, that casualty officers should bear in mind the dangers that are associated with the indiscriminate use of radiography.—I am, etc.,

PHILIP H. ADDISON
Secretary,
Medical Defence Union
London W.C.1

SIR,—As a casualty officer I find Mr. D. F. Thomas's letter (10 April, p. 105) more than welcome. After a month or so at the job it is often possible to be reasonably certain about the absence, or certainly the irrelevance, of fractures in many minor injuries and one tends to order fewer *x*-rays. This is not easy. Many patients consider an *x*-ray examination to be a therapeutic right—indeed to some it has an almost mystical quality—and with the recent bad publicity enjoyed by casualty departments as a whole, the pressures on an inexperienced casualty officer to order *x*-rays indiscriminately are difficult to resist. One may try to do so but it is often much quicker to complete an *x*-ray request form and "satisfy" the patient than to spend five minutes explaining why one is not ordering an *x*-ray, and still be left with a suspicious patient at the end of it.

Too many *x*-rays have the insidious effect of precluding thought, encouraging scanty clinical examination, and reducing the time spent talking and listening to patients, not to mention the unnecessary burden of an already overloaded radiology department.

It is sad to reflect that the easiest way for the casualty officer to keep his nose clean is to *x*-ray everything in sight.—I am, etc.,

W. A. BLISS
Basingstoke District Hospital,
Basingstoke, Hants

SIR,—About 20 years ago I wrote a letter to a weekly medical journal almost identical with that of Mr. D. F. Thomas (10 April, p. 105). It had the same effect that Mr. Thomas's also will have: damn all. Why? Because the expensive incompetence illustrated in this example lies in the sheer unworkability of the system and not in lack of intelligence or conscientiousness of the doctors. Unfortunately, vested interests and/or intellectual dishonesty obstruct a remedy.

There surely cannot be any doubt that two separate clinical examinations, with an appropriate interval between, are more valuable (and in the end cheaper) than one examination plus a routine *x*-ray. *But the two examinations must be made by the same doctor.* In these circumstances the second examination takes a matter of mere seconds because the case is remembered and the reason for the second attendance is remembered; it will then often be obvious even to the patient that an *x*-ray is no longer needed.

The root of the inefficiency of the present system is that at almost every attendance the patient is seen by a different doctor. Instead of identifying himself with the patient's welfare the doctor seeks first and foremost to protect himself from criticism when the patient is seen by someone else the next time. This is done by transferring responsibility to the *x*-ray department or the path. lab. This results in every follow-up attendance being a first attendance for the new doctor, and it will therefore take just as long as a first attendance and produce just as large a shower of special examination requests as a first attendance. And on top of all the patient is not satisfied because it is a different doctor.

There can be only one answer for the patient and the taxpayer. The casualty departments (and first attendance accident services) must be staffed by men making it a permanent career.—I am, etc.,

J. CHARNLEY
Centre for Hip Surgery,
Wrightington Hospital,
Wigan, Lancs

SIR,—Mr. D. F. Thomas's letter (10 April, p. 105) reminds me of a recent incident in a large London hospital. A child in the care of its *au pair* girl fell on its head in Kensington Gardens, cried immediately for a few moments, and then carried on playing. The *au pair* girl reported the incident to the mother who promptly sent child and *au pair* to the local casualty department, she herself being so unconcerned that she did not bother to personally accompany the child.

I later observed this very happy and lively little boy running round the *x*-ray department playing hide and seek with the radiographers, while awaiting an *x*-ray of skull ordered by the casualty officer.—I am, etc.,

JOHN H. SWAN
London W.13

Mind and Childbirth

SIR,—Did any of the 800 people at the Third International Congress of Psychosomatic Medicine in Obstetrics and Gynaecology (17 April, p. 120) mention spinal anaesthesia during delivery? It is the only help I ever needed but never received from any obstetrician (or psychiatrist) in the course of five deliveries.

I shall wait till my own daughters and future daughters-in-law are half way through their first delivery before asking them whether they want to continue relaxing, or have a spinal anaesthetic. Or will someone conduct a survey of responses from mid-dilated primiparous patients before then?—I am, etc.,

JEAN MASON
Bolton, Lancs

Torsion of the Testicle

SIR,—Mr. R. G. Notley (27 March, p. 728) gives a timely warning of the risk of missing a torsion of the testis. However, I feel that his statement that exploration of the testis should be undertaken on the assumption that epididymitis does not occur in young people without urinary infection must be challenged.

There is no doubt that there are an increasing number of just such cases. These cases run a typical course, though recovering rather slowly. There is no evidence of torsion and in any case they do not result in gangrene or later atrophy. The crux of the matter is accurate diagnosis, and this surely does not excuse surgical intervention because one has no confidence in one's ability to make such an accurate diagnosis. Much harm can come from quite unnecessary intervention, especially if infection is present.—I am, etc.,

W. D. PARK
Oldchurch Hospital,
Romford, Essex

Psychiatric Intervention and Suicide

SIR,—With reference to Drs. S. Greer and C. Bagley's article (6 February, p. 310), I wish to make the following observations.

The conclusion that psychiatric intervention is associated with a significant reduction in subsequent suicidal behaviour may only be the deceptive reflection of the various degrees of patients' willingness to receive psychiatric treatment; in other words, those who are most averse to psychiatric treatment bear the worst prognosis and vice-versa.

It would have been interesting to know the proportion in the two control groups who refused an appointment, and those who accepted one but failed to keep it subsequently. Such details can readily be obtained from outpatient records. A very high proportion of cases of attempted suicide fail to keep subsequent outpatient appointments given following an initial psychiatric interview.—I am, etc.,

V. S. NEHAMA
Prestwich Hospital,
Manchester

[1] Maddison, D., and Mackey, K. H., *British Journal of Psychiatry*, 1966, **112**, 693.
[2] Clifton, B. S., Mackey, K. H., and McLeod, J. G., *Medical Journal of Australia*, 1965, **1**, 63.

Suicide Prevention

SIR,—In their otherwise illuminating article on "Suicide Prevention" (6 February, p. 310) Drs. S. Greer and C. Bagley make but scant reference to the part played by the social services. From my own experience I would say that the greatest common factor in all cases of suicidal despair is loneliness, not only in the elderly and socially isolated but in the many whose troubles seem (to them) too personal or too shameful to be disclosed to their families, friends, doctors, or priests—even, sometimes, to the psychiatrists. Rarely do such unfortunates require medical help. Rather do they crave befriending and acceptance by some fellow human-being, who can dispel their loneliness, renew their spirit within them, and restore their belief in themselves.

Can psychiatrists, handicapped as they are by both their image and their enormous work load, fulfil this role? Can they listen patiently to a cathartic abreaction hour after hour, regardless of time, until the patient runs out of steam, feels better for it, and himself calls the halt? Can they dash out at a moment's notice to pick up a drugged patient from a remote phone-box and whisk him into casualty? Can they stay up all night with a desperate razor-clutching patient who refuses all medical intervention; and continue—in relays—throughout the next day until the crisis is past and the razor relinquished; and thereafter not only keep in close touch