ence) to work on that assumption.—I am, etc.,

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Dental Anaesthesia: The Final Act

SIR,—For the reasons given in your columns by Dr. J. G. Bourne¹ I fully support your campaign to phase out the dental operator/anaesthetist—provided that those who will be giving the anaesthetics are properly trained for this work. Everyone will agree with the final statement in the 1967 Report on Dental Anaesthesia,² "... there is a need for considerable and rapid expansion of refresher courses . . ."; yet here we are, eight years later, and little or nothing seems to have been done.

You refer in your leading article (24 May, p. 408) to Mr. Rodney Swiss's view that, except in emergency, no dentist should attempt to act as operator and anaesthetist combined, and then go on to state that this was at the heart of my long libel action. That is not true. I brought the action because the Birmingham team of investigators who originated the adverse reports in "Physiological Responses to Intermittent Methohexitone for Conservative Dentistry,"³ stated that they were using my "minimal-incremental" technique (their para. 4) when, in my opinion, they were not (their para. 7), and that "several deaths associated with this technique have been reported in the press." They were also credited with giving frightening and differing accounts to lay newspapers and on television before publication in the *B.M.J.* That this was the "heart of the action" was made clear by me in your columns long beforehand.⁴

With well-trained administrator, surgeon, and staff, together with adequate facilities, I remain convinced that for simple surgery and conservation this method, properly administered, has a valuable place in dentistry. It can be safe, pleasant, and by raising the acceptance rate for suitable patients, improve the status of both dentistry and anaesthesia.—I am, etc.,

S. L. DRUMMOND-JACKSON

London W.1

¹ Bourne, J. G., *British Medical Journal*, 1973, 4, 611.

² Ministry of Health, *Dental Anaesthesia. Report of Joint Subcommittee of the Standing Medical and Dental Advisory Committee on Dental Anaesthesia*. London, H.M.S.O., 1967.

³ Wise, C. C., et al., *British Medical Journal*, 1969, 2, 540.

⁴ Drummond-Jackson, S. L., *British Medical Journal*, 1969, 3, 474.

Genitourinary Medicine

SIR,—I wish to join your correspondent Dr. F. J. G. Jefferiss (24 May, p. 446) in protesting against renaming venereology "genitourinary medicine." This is another of the latter-day euphemisms which began by expunging the term "asylum" (a perfectly appropriate and indeed beautiful word meaning only a refuge) and have since substituted for precise terms denoting different degrees of mental defect the single ambiguous term "handicap," reminiscent of sport rather than neurology. But I object to the new term for another reason—namely, that it means, or should mean, something quite different. I believe I was one of the

first to protest against urology being regarded as the province solely of the surgeon, in view of the fact that drugs in great variety are now the mainstay of treatment for infections in this area. In the Lister lecture to the Royal College of Physicians, Edinburgh, in 1958 on "Chemotherapy of Infections of the Urinary Tract" I said: "Urology is usually regarded as a purely surgical specialty, but I suggest that there is also a need for the medical urologist, the physician equipped with not only the knowledge but the determination and patience necessary to ensure that these patients become well and remain so." I am thankful that the specialty of medical urology is now well established—witness the work of Stamey and Kass in the United States and of Cattell, O'Grady, and Brumfitt in Britain. I submit that "genitourinary medicine" is a term much more applicable to this type of work than to the treatment of venereal disease, which after all frequently involves many parts of the body other than the genitourinary tract.—I am, etc.,

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Emigration of Doctors

SIR,—Both Professor N. R. E. Fendall and Dr. A. J. R. Waterston (26 April, p. 190) have taken exception to my reference to medical auxiliaries, which is unwarranted. Professor Fendall says that "a discredit to a deserving but largely unrecognized cadre of front-line health workers" has been done, while Dr. Waterston accuses me of making "disparaging remarks" about medical auxiliaries and says that I have condemned "attempts to alter the medical course or train more auxiliaries in the effort to improve the nation's health." I quote from p. 670 of my second article (22 March): "there is undoubtedly a place for medical auxiliaries in developing countries, and their production could solve some of the problems there" and "to have more paramedical and auxiliary personnel to assist but not replace doctors in developing countries might well be worth exploring." Further comment seems unnecessary.

Professor Fendall then goes on to comment on the "argument about who shall put up the barriers—donor or recipient country." I cannot see that there is an argument. On the last page of the second article I concluded that "barriers to prevent doctors from leaving or entering some countries will not solve this problem." I explained at length that this was not a barrier problem but a supply and demand problem.

He then points out that a given country may be both donor and recipient and that "much is made of the outflow from underdeveloped to developed countries." I did point out that some countries acted as donors as well as recipients. However, much has to be made of the outflow from developing countries, because they gain far less than they lose. Considering India, Pakistan, and Sri Lanka, I doubt whether there is even a handful of doctors who have migrated here from the developed countries in contrast to the thousands who have left them. I cannot accept that what we in the developing countries have gained through the "exchange" that Professor Fendall refers to is more than a fraction of what we have

lost. Some years ago, a U.S. Senator pointed out that the total aid that the United States had given India, Pakistan, and Ceylon was less than what it would have cost the United States to train the doctors and engineers who had been trained in these countries and had migrated to the United States.

The brain drain was certainly discussed at length at the Fourth Commonwealth Medical Conference and will undoubtedly be discussed at the fifth, sixth, and seventh, but there is little evidence to suggest that anything constructive will be done to settle this problem. Professor Fendall's address at the conference with regard to health care and education in Sri Lanka made headlines in the local Government-controlled press. I do not doubt his sincerity, but when foreign experts decide to offer advice to developing countries on this and other matters they must take particular care to study the local scene in detail with special reference to the way this well-intentioned advice may be misused or misinterpreted to further some political ideology.—I am, etc.,

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Inhibition of Prostaglandin-induced Bronchoconstriction

SIR,—Dr. K. R. Patel's article (17 May, p. 360) was very interesting. The result which was of greatest interest to us was that thymoxamine failed to inhibit the bronchoconstriction produced in asthmatics by inhaling prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$). This is contrary to our experimental findings in normal subjects pretreated with another α -adrenoceptor blocking drug, indoramin. Bronchoconstriction was induced by inhaling a nebulized solution of $PGF_{2\alpha}$ to a total dose of about 25 μ g; this produced about the same fall in airways conductance as that shown by Dr. Patel, but it was almost completely inhibited by taking 80 mg indoramin by mouth 45 min before inhaling the prostaglandin. Like thymoxamine, indoramin has antihistaminic properties as well as being an α -receptor blocker; it is devoid of anticholinergic activity.¹ We wonder why there is this difference. The most obvious difference between the procedures is in the subjects, but it may also be referable to the fact that indoramin is concentrated in lung tissue and hence may exert a more powerful effect than an equivalent dose of thymoxamine. On the other hand, the difference in chemical constitution between the two drugs may be important and may have implications relevant to the chemical mechanisms put forward as a hypothesis by Dr. Patel.—We are, etc.,

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¹ Variava, D. H., and Turner, P., *Journal of Pharmacy and Pharmacology*, 1973, 23, 629.

Fibre Content of Bread

SIR,—In his criticism of the B.B.C. film Mr. C. L. Copeland (31 May, p. 503) brings out the very points that I advance in my book¹ as the reasons for incriminating the refining of the sugar far more than the re-