many of the doctors in practice today owe their vocation to the example they so unselfishly gave. I wonder if young people nowadays will see medicine in this light?—I am, etc.,

ANTHONY D. CLIFT

Manchester

Drug Dosage Error

SIR,—We request use of your columns to warn of a dangerous drug dosage error in the article on infective endocarditis by one of us (P.B.B.) in the new (14th) edition of the *Textbook of Medicine* (W. B. Saunders Company, publishers). The error is in the sixth paragraph, first column, page 315, where the recommended dose of gentamicin is given as 50 to 100 mg per kilogram body weight. The correct figure should be 1 to 1·5 mg per kilogram of body weight, intramuscularly or intravenously, every eight hours. We would also like to amend the drug dosage of karamycin which appears in the same paragraph as 10 to 20 mg per kilogram body weight to read, mg per kilogram body weight, intramuscularly or intravenously, every eight hours.

The errors were discovered after several thousand copies of the book had been distributed in May and June of this year. All copies released by the publishers in July and afterward will contain a correction. The publishers are sending notices about this to all hospitals and to all booksellers and to purchasers whose names are known, but there is no way to locate everyone who may possess an early copy of the book. We hope that readers of this notice who know anyone in possession of a copy released during the first two months will call the errors to that person's attention.—We are, etc.,

PAUL B. BEESON
WALSH MCDERMOTT

Veterans Administration Hospital,
Seattle,
Washington, U.S.A.

Deaths in the Dental Chair

SIR,—When the more recent history of dentistry comes to be written the malign influence of the fee-for-item-of-service principle coupled with an over-enthusiastic and indiscriminate adoption of intravenous anaesthesia, with the operator often filling both roles, may well be noted, as in some measure the possibilities of greater productivity—no bad thing in itself—could well have influenced its wholesale adoption. The dental supply companies were not slow to note this trend, producing a range of sophisticated equipment facilitating—indeed, largely compelling—a fully supine position of the patient, so essential of course for general anaesthesia, and from this has followed a tendency for students to be taught that all conservative and many other procedures should be undertaken this way. Whether this tendency has merit is open to argument. Some feel that with wholesale adoption of "going-to-sleep" procedures the dentist is reduced to the role of operating technician having no real personal contact with patients. The sequence of mishaps so admirably documented in the *B.M.J.* may well redress the balance in favour of local anaesthesia, with the patient in whatever position he or she and the dentist feel most at ease with each other. Mr. G. G. P. Holden (12 July, p. 100) stresses the value of overall team care should going-to-sleep procedures be adopted, this being confirmed by the statement of Sir Rodney Swiss (24 May, p. 453), though possibly both could have stressed the continuing value of local anaesthetic methods of pain relief as a useful and perhaps safer alternative.—I am, etc.,

ROBERT CUTLER

Surbiton, Surrey

SIR,—Sir Rodney Swiss (24 May, p. 453) and the Chief Dental Officer of the Department of Health, Mr. G. D. Gibb (5 July, p. 51), echoing popular opinion, have made ex-cathedra pronouncements banning the operator-anaesthetist and effectively, therefore, the incremental methohexitone method of anaesthesia. Such pronouncements, though seeming so obviously right, sometimes turn out to have been a mistake. This ban, I believe, is a retrograde step in dentistry. It will cause many people, including those who most need treating, to shun dental treatment.

If Sir Rodney and Mr. Gibb were to make a careful study of all the accumulated evidence on the causes of deaths in the dental chair they might come to agree that the incremental methohexitone method, conducted by a *well-trained* operator-anaesthetist *team*[1] and reserved for dentistry that is easy to perform—simple extractions or conservations taking at the very outside 10 to 15 minutes—is safe and should not be denied to suitable patients who wish to have it.—I am, etc.,

J. G. BOURNE

Salisbury, Wilts

1 Bourne, J. G., *British Medical Journal*, 1967, 3, 616.

Public Abortionists

SIR,—I believe it is generally accepted that the practice of medicine is concerned with the diagnosis, treatment, and prevention of diseases, though I am aware that some members and sections of the profession see themselves as fulfilling a much wider role as experts in all aspects of human behaviour and as social engineers. Abortion may properly be regarded as a medical matter when it is intended to arrest or prevent a pathological process, but when its objective is social convenience or the avoidance of personal or financial embarrassment it is, I submit, non-medical. Therefore if Parliament wishes to allow women to dispose of unwanted fetuses on purely social grounds let it provide appropriate facilities, with suitably trained public abortionists, outside the hospital service and separately funded. It may be that some members of the profession would be willing or consider it their duty to apply for such appointment: if so, so be it.—I am, etc.,

R. D. FRANCE

Cambridge

Miracle Cures in Parkinson's Disease

SIR,—I am sure that the title and last paragraph of your leading article Miracle Cures in Parkinson's Disease (5 July, p. 1) was not meant to imply that levodopa was a miracle or a cure. Certainly levodopa has been a great step forward in relieving the bradykinetic part of the syndrome and to some extent the rigidity, thus making the lot of these patients so much better. However, as every general practitioner and neurologist will know, there remain problems even with the most modern version of the drug, particularly after three or four years of treatment—for example, the oral-buccal dyskinesia which tends to reduce dosage, sometimes to ineffective levels, the "on-and-off" syndrome, and the falls which seem so difficult to prevent as the disease advances. Tremor also remains a difficulty, especially when of the intentional type.

Precise stereotactic treatment did, and still may, abolish tremor and rigidity in 80% of patients.[1] In most it remained abolished after well-planned and executed lesions, but many patients gradually deteriorated because of uncontrolled and progressive bradykinesis. Levodopa has changed that significantly. In 1955, when stereotactic surgery began to prove itself, we did not call the treatment a miracle, but it was tempting at times. We also realized its limitations, dangers of side effects (especially to speech and voice volume in bilateral lesions), and that bradykinesis remained a problem. There remain a number of indications for skilled stereotactic surgery.—I am, etc.,

F. JOHN GILLINGHAM

Royal Infirmary,
Edinburgh

1 Gillingham, F. J., *et al.*, *British Medical Journal*, 1960, 2, 1395.

Sex Aids

SIR,—Nobody today would dispute that sexual intercourse should be satisfying to both parties, and Professor P. Rhodes (12 July, p. 93) is right to say that the doctor's first duty is to give individual advice to those who seek it. That, however, is not our sole duty. As a profession we should be concerned with the biological consequences of sexual behaviour and attitudes to it.

The commercial exploitation of sex pays scant regard to possible psychological trauma to sensitive individuals and none to possible long-term biological consequences. Yet medical science is itself responsible for the fact that it is now possible for the sexual act to be *totally divorced* from its biological purpose. We do not know what the long-term biological consequences of this will be on man as a species.

I suggest that the need for toleration and understanding of individual behaviour should not blind us to the importance of these wider issues. I hope some of your contributors in the current series will have the courage to discuss this aspect.—I am, etc.,

E. O. EVANS

Stratford-upon-Avon

Deafness in Paget's Disease

SIR,—In their interesting report on deafness in Paget's disease, Mr. P. M. G. B. Grimaldi and others (28 June, p. 726) are possibly being less than fair when they question the diagnosis of deafness due to Paget's disease in our paper.[1] This presupposes that deafness cannot occur except when there is gross