effects should "have the fullest possible confidence" in her method.

It may be that the confused image some women have of oral contraceptives is a reflection of the difficulties many doctors clearly have in deciding when the above symptoms are a sign of serious biochemical alterations. If this is the case, it may be even more difficult for health personnel who are not qualified medical practitioners to dispense these pharmacologically active compounds with the high standard of care that is expected in Britain.—I am, etc.,

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1 Herzberg, B. N., et al., *British Medical Journal*, 1971, 3, 495.

2 Office of Population Censuses and Surveys, *Family Planning Services in England and Wales*, London, H.M.S.O., 1973.

3 Royal College of General Practitioners, *Oral Contraceptives and Health*, London, Pitman Medical, 1974.

4 Beral, V., *Lancet*, 1974, 1, 1280.

5 Potts, D. M., and Swyer, G. I. M., *British Medical Bulletin*, 1970, 26, 26.

Status of Ward Sisters

SIR,—Mr. R. V. Clark (12 October, p. 105) in referring to the report of the Halsbury Committee on the pay and related conditions of service of nurses, expressed the view that the ward sisters "came out badly compared with other branches of the profession." In support of that view he says that "district nurses and health visitors are in Grade I and will receive a higher salary than ward sisters, who are placed in Grade II." This represents a misreading of the report.

Health visitors are indeed in the nursing sister/charge nurse I grade. This maintains their established lead over the ward sister (at present there is only one grade of ward sister) and takes account of the fact that health visitors, in addition to being State registered nurses and holding a midwifery qualification, are required to hold a further statutory qualification—the health visitor's certificate—which involves one year of study in an establishment of higher or further education. District nurses, other than those also holding health visitor and midwifery qualifications and undertaking combined work, are in nursing sister/charge nurse II grade—that is, the grade in which the traditional ward sister is also placed.

Thus the district nurse and the ward sister will be in the same salary grading. This represents an improvement in the salary of the district nurse for which the profession has been pressing to take account of the increasing intensity and complexity of domiciliary nursing. It also seems appropriate in the context of an integrated service that those who are responsible for the organization and provision of nursing care respectively in the hospital and in the community should share the same grading.

However, the Halsbury Committee recommends "the introduction of a higher level of ward sister, in line with the Briggs Committee's proposal." This ward sister would be in the nursing sister/charge nurse I grade—that is, the same grade as the health visitor; however, this new grade cannot be introduced until the nurses' and midwives' Whitley Council has agreed the criteria for entry to that grade. The Royal College of

Nursing attaches great importance to opening up the career structure for the clinical nurse by the establishment of this new grade and will use its influence to achieve early action on the determination of the necessary criteria.

Finally, I would like to say that the Royal College of Nursing warmly welcomes the emphasis which the Halsbury Committee has placed on improving the salary levels of nurses at clinical level—that is, those engaged in the practice of nursing in both the hospital and community services. This accords with one of the main points in its own evidence to the committee.—I am, etc.,

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Deaths during Dentistry

SIR,—I recently attended the inquest on an apparently healthy young woman aged 20 years who died following treatment for a few holes in her teeth. In brief, she received about 140 mg of methohexitone, 10 mg of diazepam, and 0.6 mg of atropine while horizontal. She then became apnoeic and cyanosed and was being resuscitated by inflation of her lungs with air (which restored her colour to pink but pale) when the pulse that had been felt in the facial artery disappeared. External cardiac massage was applied and she was transferred to a local hospital, where an E.C.G. showed asystole. Normal heart beat returned only after bicarbonate therapy. She remained comatose with fixed dilated pupils and papilloedema and died approximately 10 hours later after two further episodes of cardiac arrest. At necropsy there was found evidence of multiple foci of myocarditis with many areas of cellular infiltration and muscle degeneration, though she had had no symptoms referable to her heart. The coroner's jury returned a verdict of death by misadventure.

There would seem to be two possible explanations of this death: simple severe anoxia or a lesser period of anoxia occurring in a patient with myocarditis—a condition in which the heart is particularly sensitive to lack of oxygen.¹ Either explanation begs the question as to the aetiology of the respiratory arrest and anoxia. This patient was being treated by an operator anaesthetist who was giving potent drugs in addition to performing the dentistry.

This case makes the fourth occurring at after treatment by an operator anaesthetist to have been reported in the first eight months of the year and this figure may be compared with an average of slightly less than one a year that occurred in the six-year period 1962-68. The published details of two of these four cases (2 February, p. 207; 10 August, p. 416) indicate that in one respiratory arrest occurred while the dentist was concentrating on making several attempts to remove difficult broken roots, while in the other the dentist was concentrating on packing the cavities with dental amalgam. The third case, about which complete details have proved difficult to obtain (10 August, p. 374), occurred during the taking of dental impressions in a young man of 28 years who had received 140 mg

of methohexitone and up to 10 mg of diazepam.² The coincidence of dosage of drugs with the above case is striking. There may well have been a fifth case involving a 10-year-old boy in Lancashire who died after nitrous oxide, oxygen, and halothane anaesthesia, though the published details (27 April, p. 224) do not make it clear whether the anaesthetist in this case was also the operator.

There has been at least one other dental anaesthetic death this year, though in this case there was a separate anaesthetist—a 13-year-old boy in the Croydon district who died of pulmonary oedema in the recovery phase of a brief nitrous oxide, oxygen, and halothane anaesthesia for the removal of two deciduous teeth (I would like to express my thanks to the coroner for letting me have the details). This death was very similar to that of a 9-year-old boy described in my review of 29 deaths.³

This excessive number of deaths occurring after treatment by operator anaesthetist would imply that prolonged dentistry distracts the operator from the continuous supervision that the anaesthetized patient needs. There can be little justification for the role of the operator anaesthetist in prolonged or difficult dentistry, though the anaesthetic hazard for the brief dental extraction lasting 10-30 seconds is probably not increased by this dual role. In view of the 1967 Ministry report³ and the coroner's comments in one case (2 February, p. 207), surely it is up to the profession to see if this practice could be curtailed. Perhaps the B.M.A. would advise the defence societies that they deprecate the use of defence subscriptions of B.M.A. members in meeting the medico-legal costs arising out of this practice. Alternatively the B.M.A. could advise the politicians that in the public interest the legal position relating to the operator anaesthetist in prolonged dental cases should be re-examined. A lead must be given or more young people will die and we, the profession, will be rightly accused of having done nothing. A sombre reflection is that if action had been taken a year ago it might, in the case referred to above, have saved this young woman's life. The defence societies may claim that they need to protect clinical freedom, but is the price of this kind of freedom becoming too high?—I am, etc.,

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¹ Tomlin, P. J., *Anaesthesia*, 1974, 29, 551.

² Blatchley, D., *S.A.A.D. Digest*, 1974, 2, 168.

³ Ministry of Health, *Dental Anaesthesia*. London, H.M.S.O., 1967.

Lincomycin and Clindamycin Colitis

SIR,—Your leading article on lincomycin and clindamycin colitis (12 October, p. 65) calls for a reconsideration of the indications for using these two related antibiotics. The following observations may be helpful in making this reconsideration.

Four years ago we found that more than 70% of the staphylococci cultured from patients attending the accident and emergency department of this hospital were resistant to penicillin. After considering several alternative antibiotics we decided to