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Correspondence

Letters to the Editor should not exceed 500 words.

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.,

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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 preclinical 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.
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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 analysed[1] 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 noradrenaline); 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