shows that none of the problems which your leading article suggests may occur do then in fact exist.—I am, etc.,

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Place of Diagnostic Radiology in Medicine

SIR,—I am surprised to note that there has been no response to Dr. J. W. D. Bull's thought-provoking paper "What is Diagnostic Radiology's Place in Medicine?" (10 August, p. 394). Perhaps this is another indication of the general apathy of the authorities as far as diagnostic radiology is concerned.

I work in a department with one of the five professors of diagnostic radiology in Britain. I was appointed some 11 years before this post was created in 1966, so that I have been able to observe at first hand the influence a chair of radiology has made, especially when the incumbent is excellent. For the past three years only has the professorial unit been housed in a modern department in the University Hospital of Wales. Prior to the creation of the chair there were nearly always vacant consultant posts in radiology throughout Wales and there was only one registrar trainee post. There was only one Fellow in the Faculty of Radiology in the whole of Wales in 1956. This year there are no consultant vacancies and we have just filled five new expansion posts. The great majority of the vacancies and the new posts were filled by consultants who were trained in whole or in part in Cardiff, and all of them have their fellowship. There are now three trainee posts in each of the three years training and these are backed by six senior registrar posts and a rotation scheme to non-teaching hospitals both in Cardiff and Swansea.

When I was first appointed it was rare for a radiologist to make any comment at the clinicopathological conferences held at the teaching hospital. If one suggested any of the more specialized radiological examinations there was a strong resistance to this both clinically and, I regret to say, often also radiologically. Today the radiologist is sought out several days before the case presentation is due and is asked to contribute to the meeting by presenting the radiological findings. Approximately 12 clinicoradiological conferences are held in the *x*-ray department every week. When we opened the new hospital we tried to support the policy whereby all inpatient films would remain in the department and would be permanently "on view." Distances in this huge hospital proved too great and this policy was too time-consuming for many clinicians and so the plan was modified. It is interesting to note that most newly appointed consultants request weekly sessions with a radiologist.

With regard to anatomy, our department is totally responsible for providing all tuition and the examiners in anatomy for the nursing degree course of the University of Wales. We lecture to second M.B. students, unfortunately in a somewhat token manner at present, but this has the advantage that very early in their career they learn a little of what radiologists can do and that the department does exist. The consultant radiologists provide a 6-week course (one afternoon a week) for the preclinical students, splitting the clinical students into groups of 12-15 students and reviewing the work of a department of radiology. During this course special attention is paid to the need for and benefit of clinicoradiological co-operation in all investigations. Other tutorials are provided throughout the clinical course at the request of students.

Thus we have evidence in Cardiff of all that Dr. Bull claims in his lecture. If the medical student is "exposed" early to the diagnostic possibilities of radiology and sees and hears the radiologist performing, then the possibility of a career in radiology occurs to him. If the training course is good and positive, then properly qualified radiologists can be produced and consultant vacancies reduced. Once this has happened, the discipline of diagnostic radiology can stand on its own merits. As has happened in Wales, our clinical colleagues, having seen the benefit of a well-staffed, good diagnostic department, have supported the need for the new posts required.

The creation of a chair gives one man a mandate to organize and develop the academic as well as the service aspect of a department of radiology. If our political masters could invest more capital money in building modern departments and our academic colleagues create more such chairs, then the diagnostic services to all patients in the National Health Service must improve and local working conditions become such as will attract recruits to radiology and, when trained, persuade them to stay and practise in Britain.—I am, etc.,

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Dangers of Oxytocin-induced Labour to Fetuses

SIR,—Messrs. W. A. Liston and A. J. Campbell (7 September, p. 606) examined retrospectively a group of patients receiving oxytocin infusion and showed that fetal distress, lower Apgar scores, and admission to special nurseries were all increased in the babies of women being so stimulated. Unfortunately, their study does not really show these effects to be due to oxytocin. A basic principle of medical statistics is that any analysis must compare like with like. In this survey we are not told the reasons for the induction or the methods of delivery. Many of the common reasons for induction are linked with problems of placental perfusion; if the fetus is considered to be at even higher risk oxytocin stimulation may well be added to membrane rupture. Hence those babies who are on the wrong side of the worse placental exchange systems were very probably in the induced and stimulated groups. This argument might not extend to the dose of oxytocin used and the differences between the high and low-oxytocin groups might not be so explained, but without knowing the background it is impossible to rule it out as an explanation of the results shown. Similarly, no consideration is given to the method of delivery, which would undoubtedly affect two of the measures of outcome (Apgar score and admission to special care nurseries). These measures may only reflect the population differences in the selected groups.

To point out, as the authors do in their discussion, that the "type of patient" in each of the groups examined was different is not to excuse the basic weakness of this study. In order to produce acceptable results a prospective randomized study must be performed. All patients who are to be induced should be included and all should have amniotomy. The women should be stratified by indication groups and randomized inside that; if possible the trial should be blind so that all have some form of intravenous infusion but oxytocin is included by random selection. In each case drip rates would start low and build up, so that the risks of myometrial over-stimulation could be guarded against, and all fetuses would be monitored by a standard continuous method, since the obstetrician would not know which patients were at increased risk from stronger stimulation. To set up such a survey taxes ethical and practical considerations, but if it is not done, we will never know if the suspicions touched upon by Messrs. Liston and Campbell are valid.—I am, etc.,

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Complications of Carbenoxolone Therapy

SIR,—Regarding the suggestion of Dr. A. N. Kingsnorth (31 August, p. 579), that a combination of carbenoxolone and an aldosterone antagonist, such as spironolactone, might help to prevent some of the complications of carbenoxolone therapy, I wish to point out that though spironolactone in combination with carbenoxolone reduces the incidence of complications, it also reduces its healing effects.[1] Thiazide diuretics do not reduce the healing rate, though they do reduce the incidence of complications.—I am, etc.,

I. D. HEATH

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1 Doll, R., Langman, M. J. S., and Shawdon, H. H., *Gut*, 1968, **9**, 42.

SIR,—Dr. A. N. Kingsnorth (31 August, p. 579) makes a plea for carbenoxolone to be combined or given with an aldosterone-antagonist-like diuretic. This is misleading since spironolactone itself has been shown by Doll *et al.*[1] to block the healing effect of carbenoxolone. The other potassium-sparing diuretics, amiloride and triamterene, are not competitive antagonists of aldosterone. However, I am not aware of any evidence to suggest that their effect on carbenoxolone therapy is different from that of spironolactone.—I am, etc.,

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1 Doll, R., Langman, M. J. S., and Shawdon, H. H., *Gut*, 1968, **9**, 42.