clinical co-operation all they really mean is that they use the foot switch while someone else does the examination. I know that one of your correspondents did just this during his training period. True close clinical co-operation is only possible where the radiologist has careful training (and the course for the FRCR is the shortest in the civilised world) and extensive experience enabling a discussion to occur on equal terms. Otherwise the clinician will invariably know more about the radiographs than the radiologist. The argument that radiologists help the non-specialist clinicians may well be true, but it would not be too difficult for, say, a vascular surgeon to discuss a chest x-ray with a chest physician as with a radiologist, although perhaps not quite so convenient.

It is simply not true, as suggested by one of your other correspondents, that no progress in radiology is possible unless it is in the hands of the radiologist. Surely the contributions made by such people as Dos Santos, Moniz, Everts, Graham, and even at the present time my colleague John Kimmouth are appreciated by radiologists? Also, in the United States there are several quite excellent centres where cardiovascular radiology and neuroradiology are carried out by clinical specialists in those fields to a very high standard indeed, and I myself have learnt a great deal from them.

As I move around in the clinical field, which is by no means confined to this single hospital but embraces the whole of the country, I am continually reminded by my clinical colleagues of the enormous waiting lists for many radiological investigations and complaints that the radiologists have neither the time nor the skills to carry out even the simpler special procedures. In these circumstances it is difficult to see how the new imaging techniques can be added to the radiological work load without making the situation worse. I suspect that this was the real reason why nuclear medicine has to a large extent been taken out of our hands. That has certainly not been the case in the United States of America.

Personally I can see no answer to the question of reducing radiological work load other than diffusion throughout the clinical specialties and among skilled technicians. Anyone who has close knowledge of the applications for training posts and others in radiology must be aware that although the numbers applying may not have gone down dramatically the quality has. Even if we take on and train many of these doctors it seems very unlikely that many will reach the high standards still demanded in general medicine and surgery, and thus the low status of radiologists to which I drew attention in my first letter is likely to continue. Some of your correspondents have been particularly offensive about the question of status and, of course, I am well aware that what one thinks of one's own personal status is an individual assessment. It is easy to delude oneself. One could spend a whole day writing "Please see films," and go home with a false sense of achievement.

Of course, it is necessary for all sections of the society to do repetitive and uninteresting work. But in industry this is often rewarded by increased payment. Low status does matter in other ways and the fact that radiology as a whole has low status is reflected in the small number of distinction awards given to radiologists (particularly at the upper end of the scale) and in the fact that the administrators are so reluctant to give us more staff, better equipment, etc, when we are competing with our clinical colleagues.

In summary regrettably I suggest that despite the views of your correspondents radiology carried out by radiologists has ceased to be generally available in Great Britain. I personally regret the fact that whereas at one stage of my career I spent my time training radiologists I now spend my time training clinicians to manage without them.

M LEA THOMAS

Department of Radiology,
St Thomas's Hospital,
London SE1

Distalgesic and paracetamol poisoning

SIR,—As Distalgesic (dextropropoxyphene hydrochloride and paracetamol) now contributes a large proportion of prescribed paracetamol available in the community we noted with interest the recent publications on paediatric poisoning by Dr T J Meredith and others (12 August, p 478) and on deaths from paracetamol poisoning by Mr J G Harvey and Dr J B Spooner (16 September, p 832). These studies and a recent study conducted in Manchester¹ suggest that if patients who have ingested excessive quantities of either dextropropoxyphene or paracetamol reach hospital the death rate from either drug is negligible. The Manchester study reported admissions for drug overdosage to North Manchester General Hospital (which serves approximately 175 000 people) during the period October 1976-September 1977. With the permission of HM Coroner we have extended this study by reviewing all deaths due to drug overdosage occurring in the City of Manchester (population approximately 491 000) in the same period.

A total of 27 deaths were recorded. The majority of these were due to barbiturate overdosage. Hepatotoxicity caused by paracetamol was seen in four cases, in each of which paracetamol alone was ingested. A further two persons who had taken excessive quantities of paracetamol died from other causes. Only one death attributable to Distalgesic was noted. In this case alcohol had also been consumed, together with a substantial quantity of tablets. Our inquiries were extended to include cases in which dextropropoxyphene was detected on forensic examination or in which Distalgesic tablets were found in the subject's possession. No additional deaths due to Distalgesic were identified. Finally, we considered the possibility that persons dying from unexplained causes associated with asphyxia or inhalation of vomit might have consumed overdoses of Distalgesic. Seven cases were studied. In only one was there any evidence of dextropropoxyphene ingestion. (This was recorded as a "trace" in gastric contents.) Interestingly, most of these subjects had taken excessive quantities of alcohol.

This study leads us to the following conclusions. Firstly, although Distalgesic is very widely prescribed, we found only one death due to Distalgesic in a review of all deaths due to drug overdosage in Manchester during the period October 1976-September 1977. Secondly, all deaths due to paracetamol poisoning occurred as a consequence of the ingestion of paracetamol alone; there was nothing to suggest that Distalgesic was implicated in these fatalities. Thirdly, there was substantial evidence to show that sudden death from asphyxia and inhalation of vomit

is frequently due to the consumption of alcohol alone. Abuse of alcohol and its involvement in drug overdosage appears to be increasing.^{2,3} We urge that great care be observed in prescribing any centrally acting agent (including Distalgesic) to an individual who is known to abuse alcohol.

In conclusion we stress that there is no evidence to suggest that Distalgesic is any less safe than paracetamol alone when used therapeutically and in accordance with the recommended dosage.

BRIAN GENNERY
Medical Director,
RICHARD LUCAS
Medical Adviser,
Dista Products Ltd

Basingstoke, Hants

¹ Sivner, A L, and Goldberg, L A, *Pharmaceutical Journal*, 1978, **221**, 5987.

² Finkle, B S, et al, *Journal of Forensic Sciences*, 1976, **21**, 706.

³ Office of Population Censuses and Surveys, *Mortality Statistics*. London, HMSO.

"Psychiatry Observed"

SIR,—Dr H R Rollin's trenchant review of *Psychiatry Observed* by G Baruch and A Treacher (16 September, p 821) was a stimulating defence of the medical model of madness and a vigorous attack against the social model. This polarisation of attitudes which exists between those who employ different models derives from their different views of reality, but it is, in my opinion, needlessly accentuated by the use of the metaphor "model." The concept of a model or models of mental illness, usefully summarised by Siegler and Osmond,¹ has had its uses but it has also had its abuses and led to counterproductive conflict.

Models are Procrustean. Almost any case can be made to fit a model by the appropriate use of an intellectual guillotine or rack; *The Ordeal of Gilbert Pinfold* can be adduced as evidence in support of almost all the models of madness. Would not a less misleading metaphor—for all metaphors are misleading—be that of a lens rather than that of a model? Each professional regards phenomena through a lens ground to certain specifications during the course of his training. Each type of professional lens imparts its own particular deflection, focusing on a different aspect of reality. The doctor looks through the medical lens, the social worker through the sociological lens, the psychoanalyst through the Freudian lens, and so on. Only a few, such as Professor Szasz or Thomas Scheff, look through a single lens which gives them an extremely biased but still real view. Most professionals look through a number of lenses placed one in front of another, like those placed in front of the eye by an optician during refraction. Psychiatrists, no matter how "medical," consider, inter alia, the family and social tensions, the labelling effects of diagnosis, and the biography of the individual; they look through many lenses, of which, admittedly, the most powerful is usually the medical.

The authors of the book reviewed seem, from the review, to look through only one lens, a sharply angled prism with a deflection to the left. Such a deflection may be dangerous for both professional and patient, but I hope that Dr Rollin was jesting when he used and praised Bernard Levin's method of invalidation by diagnosing those whose views differ from his own as being mentally abnormal (he