or anticipation of pain, cannot or will not relax, and which has not been, so far as I am aware, described in textbooks or taught in medical schools. The patient is asked to press his head hard back into the pillow. This simple action contracts the erector spinae, and in 19 cases out of 20 the abdominal muscles, which are antagonistic, promptly relax. Moreover, this draws the attention of the patient away from the part to be examined, and a gentle "patter" of conversation on the part of the doctor keeps it away. The principle of contracting a group of muscles in order to relax an antagonistic group is probably also the basis of Dr. Price's method.—I am, etc.,

London, S.E.5.

BERNARD J. FREEDMAN.

"Unjustified" Use of d-Tubocurarine Chloride

SIR,—Dr. T. Cecil Gray (Nov. 8, p. 745) has drawn attention to what he describes as the "unjustified" use of *d*-tubocurarine chloride during anaesthesia for operations upon the head and neck. While agreeing with Dr. Gray in this respect I wonder whether he has not fallen into a similar fault in advocating the use of *d*-tubocurarine chloride in caesarean section—a procedure which he describes so ably in your issue of April 5 (p. 444).

To my mind the only possible reason for administering curare preparations to caesarean sections must be for its effect in relaxing the tone of the abdominal musculature, but surely this is quite unnecessary "since the muscles have been well stretched during pregnancy" (H. E. G. Boyle and C. L. Hewer, *J. Obstet. Gynaec. Brit. Emp.*, 1924, 31, 264). This relaxation can be observed quite easily when the obstetrician sews up the peritoneum, which latter can be lifted some inches above the level of the wound.

The increase in uterine tone observed in Dr. Gray's cases is almost certainly due to his use of thiopentone, "kemithal," or *light* cyclopropane, either alone or in combination, as can readily be demonstrated by omitting the administration of curare. Thiopentone and *light* levels of cyclopropane anaesthesia increase the contractility of the uterus, and since 1943, when we finally recognized this effect at King's College Hospital, the routine use of "pituirin" has been abandoned after the employment of these anaesthetics. The first caesarean section ever to be performed under kemithal anaesthesia was at the same hospital, and the surgeon was Mr. John H. Peel; the date was Nov. 23, 1944, and in that and succeeding cases we rapidly came to recognize that this drug too had a similar tonic action on uterine muscle.

Apropos of the above, I well remember the first time I administered a *light* cyclopropane anaesthetic for a caesarean section performed by the present P.R.C.O.G. Up to that time it had been his routine to inject pituitrin into the wall of the uterus just before making the uterine incision. On this occasion he persisted with the usual routine, but as his scalpel pierced the uterine wall the surgeon was hit smartly in the face by a geyser of liquor amnii and momentarily incommode. Such an exhibition had never occurred while using gas-oxygen-ether and was the first of many instances (such as those attributed by Dr. Gray to the employment of *d*-tubocurarine chloride) which made us conclude that these three anaesthetics were uterine stimulants. Incidentally this property makes them useless for intrauterine manipulations or external version, although *deep* cyclopropane anaesthesia (which would never be used during caesarean section) does relax the uterus.—I am, etc.,

King's College Hospital.

A. H. GALLEY.

Waiting for Operation

SIR,—A. B. is referred by his medical attendant to a particular consultant at hospital. A diagnosis of early carcinoma of the stomach is made and confirmed. The patient is advised to have an operation, to which he agrees, and he is put on the waiting-list for admission. Presumably the consultant has entered into a contract with the patient and his doctor to carry out the treatment. The patient is not admitted for six or even twelve months, and the growth becomes inoperable.

Is this the responsibility of the consultant or the committee of management of the hospital? Should the law decree that the onus is on the committee of management, is it not incumbent upon the committee to review the number of patients on

their waiting-list and to advertise or otherwise make known to all concerned what prospects they envisage of fulfilling the contracts to which they are party? Your decision on these questions is a matter of national importance.—I am, etc.,

London, W.1.

HAMILTON BAILEY.

** Our Legal Correspondent writes: Any cause of action must be founded either on contract (agreement between the parties) or tort (civil wrong; in this case failure to use proper care). In each case the burden of proof is upon the patient. To succeed in an action for breach of contract he must show that an agreement, express or implied, existed to admit him to hospital or to operate on him, or both, while the growth was still operable. If he contracted for operation with the consultant, or for admission with the hospital, on this understanding and could prove it, he might have a chance of success. It is, however, hardly conceivable that either a consultant or a hospital would undertake such an obligation in these days of shortage of beds and would fail to tell the patient that he must wait his turn. Neither the consultant nor the hospital is required to do the impossible. If the patient seeks to found his action in tort, he must prove that the consultant or the hospital, or both, failed to use reasonable care. He might succeed if he could show that it would have been reasonable to warn him of probable delay and that he had not been warned, or that he had been wrongly deprived of his turn in the list, or if there was some other circumstance indicating negligence. Otherwise he would have no chance of success at law; and it may be said generally that in order to succeed he would have to prove a very exceptional state of facts. If he did succeed against the hospital, the committee would certainly be wise to make sure in future that they could not be taken to promise anything they could not perform regarding the interval of time between the acceptance of a patient and his admittance.—ED., *B.M.J.*

Morphine in a Patent Medicine

SIR,—In a medico-legal note (Sept. 27, p. 511) you referred to a case of death in a small child after drinking a quantity of a patent medicine sold for the purpose of relieving infantile disorders. You gave the quantity of morphine in the bottle but stated that it was not disclosed how this figure was ascertained. Actually, the Manchester City Analyst gave the quantity as a result of his analysis, and gave his evidence on oath at the inquest.—I am, etc.,

Salford, 7.

STANLEY HODGSON,
Deputy Coroner, Manchester.

SIR,—Dr. Paul B. Woolley (Nov. 8, p. 747), in quoting *The Chemist and Druggist Year Book* as his authority on dangerous drugs legislation, appears to have misinterpreted the paragraph he cites. Paragraph *e* (p. 339) (so far as it affects morphine) states that any solution or dilution of morphine in an inert substance is subject to the Dangerous Drugs Regulations; other preparations of morphine—i.e., preparations which are not solutions or dilutions in an inert substance—are subject to the Regulations if they contain not less than 0.2% of morphine.—I am, etc.,

London, W.C.2.

O. F. C. BROMFIELD.

Vaginal Temperature

SIR,—Dr. John Hankinson (Oct. 11, p. 574) has drawn attention to the dangers which may accompany the taking of vaginal temperatures. A further similar case has within the last few days come under my care in which a woman had accidentally introduced a clinical thermometer into the bladder. She had been practising this procedure for some twelve months, not for the purpose of birth control, but in an endeavour to become pregnant. No trouble had previously been experienced until one morning she failed to find the thermometer and concluded it had been mislaid in the bedclothes. About midday, however, she experienced a sharp pain in the lower abdomen and some dysuria. It then became apparent where the thermometer was, and she sought medical advice.

An x-ray examination confirmed the presence of an intact thermometer in the pelvis, and the passage of a sound revealed the foreign body in the bladder. After preliminary dilatation of