There are some important points to this letter, however, particularly regarding what is referred to as the non-medicalisation of bereavement.

We are ignoring our duty as professional carers if we do not concern ourselves with the imminently bereaved and are just brushing under the carpet something we find difficult to deal with. We draw up from our responsibility to bereaved loved ones. We invite relatives, without coercion or callousness, into the resuscitation room and give information in a compassionate way. Infringement of autonomy and privacy of the patient is therefore potentially distressing and may be seen by the patient as a lack of respect and confidence.

I wholeheartedly endorse the view that reduction of shoulder dislocation should be a distress free experience and that force should not be involved but disregard of "gold standard" means use of potent drugs.

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The author replies
I agree with Mr Lannigan that it is indeed possible to achieve a painless free reduction of a dislocation within a few minutes of the patient's arrival in A&E without the use of injected drugs by encouraging the patient to relax and to avoid sudden painful movements of the arm during resuscitation. As a minimum I would recommend that all patients should be offered a trial of Entonox which will certainly facilitate the reduction process in the majority of cases. It is probably unwise to attempt reduction of an anterior glenohumeral dislocation without prior radiography as there may be a mediastinal collapse over whether a fracture evident on a post reduction film was present before reduction or occurred as a result of the reduction manoeuvre. The only circumstance where I would reduce an anterior dislocation without prior radiography would be in recurrent dislocations who have not fallen onto the arm and who sustained the dislocation with a combination of simple abduction and external rotation.

Do we need to be propped up with protocols?

EDINBURGH

The authors reply
We agree entirely with Professor John Henry's comments that CS "gas" is not a gas, and reference to this fact was made in the discussion.1 We used the term CS gas due to the popularity and widespread use in the medical literature, not as a description of its chemical properties. We made the point that fanning with air (electric fan) caused contamination of the accident and emergency department and CS powder (crystals) converting to a solution on the skin surface of the patient should be managed by eye irrigation rather than air currents.2