

Developing Skills in Clinical Photography

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It is evident to every reader that most scientific journals could not be produced were it not for illustrations. Journalists are taught early in their training that one picture is worth a thousand words. Is there a descriptive passage anywhere that can describe the beauty of the Pieta, the manliness of David, or the serenity of the Mona Lisa? Although the average photograph is merely two-dimensional, proper lighting, the appropriate field and framing, and requisite magnification are but several of the factors involved that can deliver an image that relates a story or a technique far better than words.

Photography is simplified today with the use of medical camera apparatus. Some equipment requires minimal preparation and skill—one merely needs to aim and shoot. There are as well, autofocus, autoexposure units that, after the simplest introductory maneuvers, will produce the most lucid and worthy reproductions.

No longer will there be failures such as poor or improper lighting of images as dark as night or as pallid as a summer day in St. Tropez. Ultra-fast film, built-in, automatic strobe units, long-life batteries, and ultra-sharp lenses are available to eliminate the common faults suffered by most clinicians who serve as novice photographers.

Certain strategies must be utilized however, even with the best of equipment, in order to obtain consistently good results.

The steel- or chrome-plated cheek retractor, or Henahan, will reflect the strobe light right back into the lens, thereby blocking out much of the vital

information being sought by the camera. A preventive technique is to have several retractors dulled with Teflon (PTFE) coatings and to reserve the use of these instruments for photographic retraction only.

Views of the maxillae, particularly deeply vaulted palates, are best taken by indirect views with the use of a mirror. Such mirrors must be front-surfaced and kept protected from scratches by storage in a soft fabric container. Often, just when the subject to be photographed comes into the exact position in the viewfinder and as the eager finger presses the shutter button, the patient exhales. The result looks like the Thames estuary in winter. In order to prevent fogging (and patient hypoxemia), the mirror can be kept in a warm water bath, or even simpler, the surgical nurse can keep a soft, steady stream of air directed over its surface during picture taking.

Intraoperative photographs, particularly if being taken for purposes of teaching or publication, should be made in a sensible and logical order. The clinician cannot begin with the proposed operative site. It simply is unconvincing if the unincised area is not shown first. Then, in reasonable sequence, the incision should be illustrated, followed by the reflection, osteotomy, implant placement, and finally, closure. Skipped steps, except when one knows what the audience or reader understands, have a tendency to create a lack of consumer confidence.

Even worse is a lack of postoperative photographs or radiographic reproductions!

If the lecturer wonders why the audience is drifting prematurely for the

coffee break, it is because he or she utters lamely:

"The film was lost in the developer."

"The patient never returned for follow-up."

"The camera store lost the roll."

Complete presentations are far more believable than fragmented case reports.

Radiographs are reproducible readily with the photographic equipment commonly in use. The x-rays can be placed on a viewbox, framed to their peripheral margins with opaque borders and exposed using the automatic camera without flash. For manual cameras, the use of a light meter and a tripod works as satisfactorily.

Patient education is enhanced with photographic illustration. Illustrations serve as excellent practice builders. Local study club invitations will increase

in direct relationship to the quality of the illustrations presented.

In addition, photographs may prove to be of benefit for problems of litigation or for other forensic matters.

As a box of slides is returned, each should be marked clearly with the patient's name, and stored in a cool, dry place. Their longevity, under such circumstances, is virtually endless.

Each truthful picture-taking practitioner must observe some basic ground rules:

1. The preoperative and postoperative photographs should show the same views with similar make-up and hairstyles. That is, no postoperative hairpieces, diamond earrings, or flamboyant décolletage when the preops pictured baldness, floppy earlobes, or turtlenecks.

2. Lighting, size of images, framing,

and head and mouth positions, both pre- and post-op, should be as much alike as possible.

3. The images should be a true and forthright presentation of the accomplishments of the clinician and not the result of photographic chicanery.

The patient should approve the making of medical photographs in advance. If they are to be shown to others, the patient should be so informed and should sign his or her consent to permit this.

Acquiring skills in the reproduction of one's clinical achievements on film is a delightful, beneficial, and rewarding activity, which adds yet another satisfying facet to the gem of clinical practice. ■