For portability, ease of administration, and speed of action in the relief of bronchospasm it would be difficult to improve on sublingually administered isoprenaline. A tablet wrapped in foil could be carried at all times. What is needed is information, based on experience of this drug, on its effectiveness in shock due to stings. It has been objected that isoprenaline might aggravate shock,¹ but the fall in diastolic pressure only occurs in the upright posture. Anyone contemplating prescribing sublingual isoprenaline should specify Aleudrin (Lewis Laboratories Ltd), because prescribing "isoprenaline tablets" can result in erroneous dispensing of Saventrine tablets (which have to be swallowed). A prior test with a half tablet (10 mg) will establish whether a patient is unusually sensitive to its chronotropic action on heart rate.

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¹ McLean, J A, *A Manual of Clinical Allergy*, ed J M Sheldon, R G Lovell, and K P Mathews. 2nd edn. Philadelphia, W B Saunders, 1967.

Smoking and acclimatisation to altitude

SIR,—I was a fairly heavy smoker for about 10 years, and at the same time active in skiing and mountaineering. On several occasions I noticed that altitude sickness either did not affect me at all or, if it did, did not affect me as seriously as members of the group who were non-smokers.

Over the years a number of friends made similar observations. The main things the smokers had in common were that we had all been on several expeditions to about 4600 m or higher, we had all either smoked less or stopped smoking completely during these expeditions, and we had all suffered significantly less from altitude sickness than our non-smoking companions. Nobody had approached the matter scientifically, but we all assumed that our tissues had become so accustomed to oxygen starvation due to the cigarette smoking that we were already partially acclimatised to altitude before setting off.

It was therefore very interesting to read the article by Dr Judith M Davies and others (11 August, p 355) on the effect on oxygen availability of stopping smoking for 48 hours. The findings in Dr Davies's pregnant women appear to confirm our subjective and unscientific conclusions about partial acclimatisation. Perhaps the British Olympic Association should now be advised to consider the cost advantages of substituting controlled cigarette smoking for altitude training in the pre-Olympic training programme. The reported 8% increase in available oxygen might produce the extra puff our athletes need in 1980.

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Unbalanced view of a rare hazard?

SIR,—I wish to comment on the published correspondence between Dr B M Laurance, a consultant paediatrician, and Mr Ian Trethowan, Director-general of BBC Television, in the columns of *Medicine and the Media* (30 June, p 1785), concerning a proposed television programme about a handicapped child.

The Association of Anaesthetists of Great Britain and Ireland is extremely concerned at the potential harm to parents and their children who await operation and anaesthesia from screening a programme which highlights an exceedingly rare occurrence—brain damage to a child after an anaesthetic for a minor operation. Indeed, this unbalanced view of the hazards of anaesthesia could easily deter parents from consenting to necessary operations on their children. It is particularly worrying to note Mr Trethowan's rather cavalier reply to Dr Laurance and the lack of consultation with our specialty.

I have written to Mr Trethowan to suggest that if the programme is to be screened a discussion should be included, with the participation of an anaesthetist, to balance the programme's potentially harmful effects and to ensure that correct emphasis is given to Mr Trethowan's claim that "problems arising out of anaesthesia are amongst the most common in medical negligence."

Our association would always be willing to assist the media with advice, and it is perhaps unfortunate that the BBC did not seek expert advice at an early stage in the planning of this programme.

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Patients before consultants

SIR,—As a valiant defence of consultant status by a consultant surgeon the article by Professor Norman Browse (15 September, p 682) takes its place at the pinnacle of that sorry pyramid. He states that patients' needs must be put before career structures and then proceeds to claim that patients are best looked after by a team of three doctors. This proposed team would consist of a consultant, a house officer, and a doctor "whose duties will stretch from helping and training the house officer to deputising for the consultant." What an interesting suggestion—having about as much foundation in reality as the Flat Earth Society. He suggests that a doctor whose training is sufficient to allow him to deputise for a consultant should spend half his time in general practice and thereby remove from patients in hospital a highly trained doctor. Of course, it is possible that Professor Browse believes that you do not need to be highly trained to deputise for a consultant. After all, he does not believe that general practice is truly a specialty in its own right. No doubt as a professor of vascular surgery he considers himself well qualified to make such judgments.

The article by Professor Browse is in one respect timely since it questions the present hospital staffing structure. Rather than beginning as he does from what a consultant considers to be his role, let that exercise begin by asking what are a patient's requirements and aspirations in hospital. Put patients before consultants. Patients expect to be under the care of a fully trained doctor while they are in hospital. If a doctor is not fully trained then it is inevitable that patients are exposed to a greater risk of wrong management. According to Doran,¹ 75% of all emergency operations at one hospital were performed by a registrar, and in the West Midlands Region 48.6% of all operations were performed by registrars. I wonder how many

consultant surgeons were operated on by registrars in the same period. It is well known that at least three out of every five registrars in surgery cannot proceed with their training owing to the present staffing structure. Thus patients probably are exposed to increased risks without any consequential benefit to society.

The medical profession needs to devise, rapidly, a hospital staffing pattern which provides a maximum of fully trained doctors to look after patients. Put patients before consultants.

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¹ Doran, F S A, *British Medical Journal*, 1978, 1, 385.

SIR,—Professor Norman Browse seems to argue (15 September, p 682) a good case for his proposed hospital career structure, certainly from the point of view of hospitals and hospital patients.

On the subject of general practice his reasoning becomes more emotional, which is perhaps significant, as it is from general practice that his recruits will, indirectly, come. He should tell us what effects his proposals will have on general practice. It is not enough, for example, merely to demonstrate how 24-hour practice cover can be provided by half-time GPs. Most patients want, within the limits of reasonable off-duty, the same, personal, family doctor in whom they can confide. If most GPs are to become half-timers, it is hard to see how that concept of general practice can survive.

Professor Browse says in his third paragraph, "But patients are what the hospital service is all about." Patients are what general practice is all about too.

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SIR,—There will be quite a few doctors who would be happy to work in the hospital practitioner grade, as proposed by Professor Norman Browse (15 September, p 682); but I am certain that their numbers fall far short of that required to provide "first-class 24-hour cover" to specialist units composed of equal numbers of consultants and house officers.

To provide 24-hour cover in one post throughout the year requires five whole-time equivalents to allow minimal off duty, annual and study leave, etc. This means that each unit would require 10 hospital practitioners, each of differing experience, making the organisation of cover incredibly difficult, even if such vast numbers were available.

The answer surely lies in the system adopted throughout much of Europe and North America. There, specialists look after all patients and only in the teaching hospitals are they assisted by any "subconsultant" staff. The system works because it depends on item-of-service payment. Of course, it is absurd to think that such a method of payment could be introduced into the NHS, but the system could work here if consultants' salaries were adjusted so that they could be expected to pay for whatever assistance they received from "subconsultant" medical staff engaged by the hospital.

As I have previously pointed out,¹ unless a price is paid for the assistance currently