CORRESPONDENCE

Television medicine Sir Michael Swann, FRCS.....	1274	Hepatitis B in the school environment E A C Follett, PHD, and others.....	1279	Vacuum pipelines for anaesthetic pollution control D W Bethune, FFARCS, and J M Collis, FFARCS.....	1283
Routine procedures in general anaesthesia P V Scott, FFARCS; M A Thompson, FFARCS; N C Hypher, MRCS.....	1275	"Fighting Spirit" Major-General F M Richardson, MD....	1280	Bleeding gastric erosion after oral zinc sulphate A A Morgan, MD.....	1283
Reactogenicity of pertussis vaccines J Cameron, PHD.....	1276	Nutrition education G Cust, MFCM.....	1280	Gin Seng and mastalgia B V Palmer, FRCS, and others.....	1284
If I had... J S Simpson, FRCS; M J G Harrison, FRCP, and L A Wilson, FRACP; B D Lask, MRCPsych; D P Choyce, FRCS; L Rose, FRCPsych.....	1276	Fall in admission rate of old people to psychiatric units K Shulman, MD, and T H D Arie, MRCPsych.....	1280	Hyperbaric oxygen B K Mandal, MRCPED.....	1284
SI, moles, and drugs P Crome, MRCP, and others.....	1277	The abuse of slides Jill Wilkinson.....	1280	Flight from specialist medicine T F Mortimer, FRCPATH.....	1284
Inhibition of fibrinolysis and abruptio placentae E N Wardle, MD; B Åstedt, MD, and I Marie Nilsson, MD.....	1277	Duodenal ulcer in Johannesburg S A R Cooke, FRCS.....	1280	Deputising services: new code of practice J W Bone, MRCP.....	1284
Hairy-cell leukaemia G F Burns, BSC, and others.....	1278	Choosing an antidepressant D E Case, DPHIL.....	1281	Hospital practitioner grade Frances F Kerr, MB.....	1284
Duodenal erosions on cimetidine therapy B D Linaker, MRCP, and S Hughes, MB....	1278	Schumann's hand injury H M Mather, MRCP.....	1281	Hospital day nurseries Eva D Alberman, MD, and others.....	1284
Antibacterial activity of cefuroxime L O Potaschmacher, FRCPATH, and K A Jefferson, FIMLS.....	1279	GP obstetrics G N Marsh, MD.....	1281	BMA and the Abortion Act J H Scotson, MB.....	1284
Contracting in or contracting out? D C Bishop.....	1279	Diseases of the respiratory system J W Todd, FRCP.....	1281	Economy in drug prescribing P D Oldfield, MB; J A Hall, MB, and G J Davies, MB; S T Swaddle, MPS; D C Wilkins, MB.....	1285
The postcoital test: what is normal? H P Didier, MRCP.....	1279	Lithium toxicity S P Tyrer, MRCPsych.....	1281	Points from letters Plasmapheresis in pregnancy (D Lee); Pilots' hearts (V B Maxwell); Self-mutilation in the severely retarded (D A A Primrose); Needle tracheostomy for acute upper airway obstruction (N Ripley); Windows in operating theatres (G A D Lavy); Checking the endotracheal tube (D Blatchley); SI, moles, and drugs (D W FitzSimons); Whooping cough (G H B Martin); Liver fluke in Britain (A T Hunt).....	1285
Who discovered the circulation of the blood? S A Khulusi.....	1279	Endometrial assessment M E L Paterson, MRCP, and others.....	1282	Correction: Cot deaths (Elton).....	1285
		Demeclocycline in congestive cardiac failure R R Ghose, FRCPED, and R S Bonser, MB....	1282		
		Aortography in infantile coarctation B R Denham, MRCP.....	1282		
		Facet joints and low back pain J A Robertson, FRCS; A H G Murley, FRCS.....	1283		

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Television medicine

SIR,—I have followed the recent articles and correspondence about television medicine with interest and concern. As so often happens in broadcasting, the opinions expressed are enormously diverse and frequently contradictory; but I would like to comment on some at least of the strands of thought.

First of all you suggest, in your leading article of 18 March (p 667), that I, as a scientist, should gather together 20 uncommitted people and listen to the conclusions they draw from watching various medical programmes. I doubt if this would be a very helpful, still less a scientific way of going about the problem, particularly as our audience research department has, at one time and another, conducted some eight surveys, involving much greater numbers of people, into the effects of medical programmes. Copies of these are available if you are interested.

I can only summarise the findings in the briefest of ways, but we discover, for instance, and perhaps surprisingly, that programmes do not in general seem to have much effect on people's subsequent behaviour—for example, in two studies only 5% or 6% of general practitioners reported that they had

been consulted by one or more patients as a result of programmes.

Nor is there much evidence of increased anxiety from watching programmes. After a programme on cancer viewers rated it seventh in a list of 20 worries, whereas non-viewers rated it tenth. Other studies showed a lesser effect or none at all.

Confidence in the outcome of treatment, however, generally showed a considerable improvement after watching—for example, of viewers of a programme on sex problems, 22% were very confident in the outcome of treatment for impotence, whereas only 9% of non-viewers felt this way.

Confidence in the medical profession also seems to increase slightly as a result of watching medical programmes—for example, following a programme on cancer 63% of viewers thought there had been a "great deal or a lot of progress." The figure for non-viewers was 52%. Following another programme 78% of viewers thought "GPs do a wonderful job," while the figure for non-viewers was 71%.

Improvements in ability to answer simple questions after watching medical programmes have been very variable, from large to small, with, alas, occasional instances of a slightly reduced ability to answer correctly.

An interesting minor point is that 40% of people say they feel squeamish about watching

operations on television, and this figure does not seem to have fallen over 20 years. But even of these a majority are in favour of showing operations with suitable warnings.

I would not want to attach undue weight to these findings, but they suggest, to me at least, that the effects of medical television programmes are modestly beneficial for most people. But surveys cannot pick up the small number of people who are upset in one way or another, and these, of course, are the ones who turn up in GPs' surgeries.

Where does the balance of good and ill lie in this equation? Some 5 million people are likely to watch a medical programme, and it looks as though some good is done to most of them. But it also looks as though one in 20 GPs get consulted by one or more patients because they are seriously troubled by what they have seen. Since there are about 23 000 GPs this suggests one or two thousand people altogether. No doubt some of these consultations were desirable in that treatment was necessary. But others no doubt were with people troubled to no purpose. On any showing, however, these must have been a very small minority of viewers and one might remember that a lot of people are worried in varying degrees about illness anyway.

In the leading article mentioned above you make a number of other points, the most important of which is the need for balance, and you instance Norwegian broadcasting, where this is enforced by Parliament. But the fact of the matter is that ever since John

Reith, more than 50 years ago, wrote the words "give both sides" on a minute asking for guidance on how to handle some problem the idea of balance has been deeply rooted in BBC thinking. This isn't to say that we always achieve it, and we are painfully and regularly reminded, in addition, that what seems balanced to Conservatives does not seem balanced to Labour. Likewise with medicine and just about everything else. In short, one is dealing with a goal that must be strived for rather than a rule that can be enforced.

You also criticise us, as do some of your correspondents, for aiming only at entertainment or the sensational. I really don't think this is fair. Even as a university lecturer I used to try to be entertaining and on occasion striking. How else does one hold the attention of audiences, even those who have the shadow of exams hanging over them? The 5 million-odd viewers of a medical television programme have no such compulsions.

Then there is the widespread and very understandable irritation of busy doctors who are filmed at length and then find that they end up heavily cut and edited. There are some genuine problems here. Most people, however well they think they are doing, in fact fidget about, don't look at the camera, fail to answer the question, ramble on, or lose their train of thought. If a producer is to be sure of getting what he needs he has to film more than he ultimately uses—even in film-making with professional actors the ratio is usually 10 to 1. The subsequent editing does, of course, put a heavy responsibility on the producer to make sure that he ends up with a true bill. And even the best of producers occasionally make mistakes. Who doesn't? People who are willing to appear on television must understand some of the difficulties on the other side. They should also try to be well prepared so that overmuch filming is not needed. But equally producers, I freely admit, do not always explain everything to the victim as well as they might. But then do doctors?

Reading all the diverse views expressed in your recent issues I am, I need hardly say, encouraged that many correspondents have a high opinion of our producers and their work. At the same time I am saddened by some of the severer criticism. In some cases this seems to me to be unfair. But in others, the "Panorama" programme on ECT, for instance, it seems to me to be justified. So what can be done to make things better?

Above all, I believe, we have to aim for expertise and sensitivity in production. This is not something that is achieved in a hurry, but I believe that we have gone a long way in the last 20 years, and the department of the BBC which produces the main series of medical programmes—science and features as it's called—rather seldom puts a foot wrong. They have their own adviser, Professor McColl, and a consultative group, with two distinguished doctors on it, keeps a general eye on the output. But several other departments—news, current affairs, documentaries, and general features—also, and inevitably, touch on medicine from time to time. They are not and cannot be experts in the same way, and it is significant that some of the complaint (from doctors at least) seems to stem from such programmes—though there is much they put out that is acknowledgedly admirable.

There is, however, one important consideration here which is often overlooked. These mainstream programmes often, and very properly, start from a different standpoint,

being concerned not so much to educate people in medical matters as to examine areas of public concern. Doctors like this sort of examination no more than politicians, trade unionists, industrialists, or anyone else. It is, nevertheless, a right and proper function of the media in a free society. But because the aim of such programmes is different they have no less of an obligation to get their facts right, to give both sides of any controversy, and to consider the effect they may have on hapless patients caught up in whatever is the area of concern. This is a difficult task and we by no means always get it right. We are, however, looking afresh at the difficulties and seeing whether our advisory procedures could be improved. In this connection I was glad to read what Michael Oliver (8 April, p 917) had to say about how well, in his opinion, our arrangements work in Scotland.

Lastly, I believe that the medical profession itself can help. Karl Sabbagh, one of our senior producers (from science and features), has pointed the way (18 March, p 713). Co-operation and trust are indeed needed. So also is constructive criticism. In this context I welcome, as do all of us in the BBC, your projected column on "Medicine and the Media." It is long overdue and considering the extent to which both sides have sniped at each other over the years I can't think why you didn't start it long ago!

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* * * Given the strong words on both sides, we should be churlish not to acknowledge Sir Michael's reasoned and constructive comments. We look forward to playing our part in appraising television programmes in "Medicine and the Media," due to start on 1 July. —Ed, *BMJ*.

Routine procedures in general anaesthesia

SIR,—Dr G C Steel (22 April, p 1049) clearly dislikes the routine prescription of oxygen for patients recovering from a general anaesthetic. That is strange, for I had always thought it to be an internationally recognised code of safe practice. Dr Steel, however, labels it "haphazard," "indiscriminate," and "a ju-ju or charm to ward off the evil spirits." Even if Dr Steel were right the theoretical dangers, dangers to which he nowhere alludes, are so remote as to be negligible; but is he right?

The "evil spirit" to which he refers is arterial hypoxaemia. Hypoxia exists, albeit clinically unsuspected, in many patients recently anaesthetised, if not in all. The mechanisms which produce it are well known.¹⁻⁴ They include residual respiratory depression, ventilation/perfusion inequalities, intrapulmonary shunting, impaired cardiac output, and the diluting effect of exhaled nitrous oxide—one component of Dr Steel's personal anaesthetic technique. The remedy—or, better, preventive—is equally well known. It is the routine *prescription* (not the "indiscriminate use") of oxygen in amounts greater than atmospheric: routine, because without direct arterial sampling it is not given to us all to be able to distinguish degrees of hypoxia which fall short of cyanosis. It is better to be safe than sorry.

Dr Steel aspires to the role of prosecuting counsel. If he thought to fly a kite or take on the academic establishment he fails on two counts: firstly, his bald and unconvincing narrative adduces evidence neither for nor against. Secondly, he employs language extravagant to the point of embarrassment, entirely inappropriate to a court of law, where, if his advice were to be taken, some of us would no doubt end. The experienced anaesthetist can, and I hope will, discount Dr Steel's ill-conceived bias. The embryo anaesthetist, however, might take it seriously. In that case failure to prescribe oxygen in appropriate amounts to every patient in the post-anaesthetic recovery area will lead, sooner or later, to the "avoidable factors" coldly remarked upon by an unsympathetic coroner.

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¹ Fink, B R, *Anesthesiology*, 1955, 16, 511.

² Nunn, J F, and Payne, J P, *Lancet*, 1962, 2, 631.

³ Nunn, J F, *Lancet*, 1965, 2, 466.

⁴ *A Synopsis of Anaesthesia*, ed R S Atkinson, G B Rushman, and J A Lee, 8th edn. Bristol, Wright, 1977.

SIR,—I cannot agree with the Personal View of Dr G C Steel (22 April, p 1049) for he seems to me to have crystallised so clearly two of the many differences between anaesthesia as it used to be and how it is today. Today's anaesthetist has grown up to trust and use endotracheal tubes and oxygen, and though there have been occasional disasters these have been offset by the advantages. Whereas the safest anaesthetic is always the one with which the anaesthetist is most familiar, there is a tendency today to avoid the necessity of passing an endotracheal tube merely because it is "vital to the maintenance of an adequate airway" but to use this procedure as part of the anaesthetic technique. Certainly there are problems with any procedure, but these are usually related more to the performance of the skill rather than to the technique itself: I am sure Dr Steel has experienced trouble with a mask and airway. It is unfortunate that the example he gives of trouble with an endotracheal tube should have occurred during a caesarean section, which is one operation in which the passage of an endotracheal tube should be considered mandatory by modern standards. How much better it would have been if Dr Steel had withdrawn his unfortunate registrar's tube into the trachea so that it could have performed its function normally. It is certainly not propitiation to the unknown gods of anaesthesia that encourages intubation in operations that may otherwise be satisfactorily anaesthetised by a mask: it is a knowledge that the use of relaxants and narcotics provides a technique that is at least as good and also results in a fully conscious but pain-free patient at the end of the operation. In fact the only technique I know that provides better analgesia immediately after the operation is the use of local blocks.

The use of postoperative oxygen has evolved from studies of postoperative hypoxaemia, even following relatively minor procedures, which have shown that this can be abolished by the judicious use of oxygen in the recovery room and ward. It is essential that if this advance is to benefit most patients then its use must become a routine whereby the occasional patient who doesn't need oxygen receives it anyway. Certainly the occasional patient who receives an epidural is hardly a