Nursing time must be allowed for cleaning and disinfecting sigmoidoscopes during a list, and more than one sigmoidoscope may be required. Nursing time is required for correctly maintaining sigmoidoscopes and disinfection equipment weekly to keep all equipment in good condition and prevent cross infection.

Sigmoidoscopy can be performed by general practitioners, but they must recognise that it is costly with important health and safety aspects.

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Lipoprotein(a) in cirrhosis

EDITOR,—H Schmidt and colleagues state that the primary site of synthesis of lipoprotein(a) has not been clearly identified.¹ This is not correct. Lipoprotein(a) consists of a particle similar to low density lipoprotein and of apolipoprotein(a). Apolipoprotein(a) exhibits a genetic size polymorphism.² We have determined the genetic polymorphism of apolipoprotein(a) in the plasma of subjects undergoing liver transplantation and in the organ donors.³ After transplantation the recipients acquire the genetic apolipoprotein(a) type of the organ donor. Our results show that virtually all plasma apolipoprotein(a) and hence lipoprotein(a) is derived from the liver.

The question that remains to be answered is where the lipoprotein(a) particle is assembled. This cannot be answered by measuring lipoprotein(a) in the plasma of patients with cirrhosis but requires more sophisticated approaches.

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Use of Lucozade and glucagon by ambulance staff in hypoglycaemia

EDITOR,—J M Steel and colleagues report the effect of training ambulance staff in using Lucozade and glucagon in the domiciliary treatment of hypoglycaemia in diabetic patients.¹ We have previously reported our experience of ambulance paramedical staff giving glucagon.^{2,3} Since we presented our findings to the British Diabetic Association in March last year we have extended the use of glucagon to all local ambulance crews. Over three years 51 patients who were severely

hypoglycaemic were treated at home by the ambulance service and only five required transportation to hospital. No adverse effects were encountered. Administration of glucagon by ambulance staff has also been reported by other ambulance units.^{4,5}

We now have three years' experience of this approach to treating hypoglycaemia. We agree with Steel and colleagues' conclusions that it is extremely useful in managing this potentially lethal condition and endorse the recommendation that this policy should be adopted by all ambulance authorities.

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Patterns of hospital medical staffing

EDITOR,—C K Connolly commends the staffing structure in the armed forces as a basis for hospital medical staffing in the NHS,¹ but the analogy is misleading. The apparent balance in the forces is achieved only through the departure of most doctors on completion of short service commissions and by the early retirement of others (with pensions) after 15 years' service. John G Temple's call for a change in consultants' working practice has been made before.² Along with a rationalisation of sites providing acute services (complicated by the growth of trusts), it is the only way in which a reduction in juniors' hours can be reconciled with a balanced career structure.³ It would, however, require a substantial reduction in the volume of work that doctors do at night. Colleagues and I have shown that doctors and other health care professionals can agree on ways in which work done by doctors at night can be postponed safely until the next day⁴ or done by other staff.⁵ Unfortunately, this has had a similarly muted response to that greeting Robin Dowie's work.⁶

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Induction of house officers

EDITOR,—In their article on running an induction meeting for house officers Rodney Gale and colleagues make no mention of a presentation from a local general practitioner.¹ In Chester, for many years, such meetings have included a 10 minute

session for a local general practitioner to meet the new intake and emphasise that general practitioners are approachable and have all themselves been junior doctors. Subjects covered mainly concern communication: the vexed questions of referral and discharge letters and who has ultimate responsibility for issuing sick notes. One of the main advantages has been to open up communication between primary and secondary care and discuss when and how general practitioners can be contacted personally or officially.

I hope that Gale and colleagues, even on a trial basis, will ask a general practitioner from a local forum, local medical committee, or college faculty to participate in their induction meetings for house officers.

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1 Gale R, Jackson G, Nicholls M. How to run an induction meeting for house officers. *BMJ* 1992;304:1619-20. (20 June.)

EDITOR,—Rodney Gale and colleagues' article on running induction meetings for house officers includes a paragraph on their evaluation of two such meetings; they mention the participants' wish for revision of cardiopulmonary resuscitation and management of trauma.¹

Poole General Hospital runs a similar induction meeting for house officers. Here, however, we include an introduction by an anaesthetist and a compulsory hands on tutorial about cardiopulmonary resuscitation. This is held the next day in the lunch hour in the junior doctors' mess, where an anaesthetist shows the management of a cardiac arrest. The house officers are guided through the ABC of cardiopulmonary resuscitation, both basic and advanced, and then each practises these skills on a mannequin, supervised by anaesthetists. They are also encouraged to liaise with anaesthetists further to gain more confidence or updating. We have always had an excellent response to this scheme and believe that it helps the house officers, as probably the most stressful event for them is managing a cardiac arrest.

In addition to this, and generally to raise standards and response to a cardiac arrest, anaesthetists give tutorials to ward staff (day and night) to provide a concerted approach to the management of resuscitation in general. Each anaesthetist is responsible for a ward or department. All ancillary staff are included and receive this tuition with hands on practice. Ultimately the patients benefit, but we believe that this helps morale and stress levels among junior doctors.

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EDITOR,—I was disappointed that in their article on running induction meetings for house officers Rodney Gale and colleagues did not mention any input from the occupational health department or say that on taking up a new appointment all house officers should be encouraged to visit the occupational health department without waiting for an appointment.¹ It is essential for health and safety at work that immunisations and vaccinations are checked and kept up to date. Moreover, occupational health departments can give advice on what other services are available, and in this department we also have a list of local general practitioners who are willing to accept temporary residents on their lists.

Until such time as NHS occupational health records are standardised and arrangements made for them to accompany staff automatically, with