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

consent, as they move within the NHS, house officers may be unaware that they are not protected against prescribed diseases such as tuberculosis and hepatitis B. It may well be that Lewisham Hospital's handbook mentions the occupational health department.

Luisa Dillner's review of *Stress and the Medical Profession* seems to confirm my views.² The penultimate paragraph suggests that doctors need an accessible counselling service and an occupational health service that is geared to recognising stress.

The standard and quality of occupational health services vary considerably within the NHS, but it is essential that all staff, including doctors, become more aware of the services they offer.

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Unnecessary hospitalisation in a psychiatric rehabilitation unit

EDITOR,—Peter H Dick and colleagues' paper highlighting delayed discharges from the Dundee psychiatric rehabilitation unit raises several points of interest to doctors in all specialties.¹ The title and introduction led us to believe that concrete proposals leading to more rapid turnover of beds would be discussed, but, sadly, they are not.

Discharge to unsuitable accommodation is mentioned and may be one method of unblocking beds in the short term. In our experience this practice often leads to rapid readmission. If the original discharging psychiatric unit or other psychiatric departments are unable to readmit these patients then either an acute medical unit or an acute geriatric unit becomes involved.

From the figures given we see that the average turnover of the Dundee rehabilitation unit is just under one patient a week, but we are not given the number of beds in the unit. As the number of beds available is often limited geriatricians may have acute geriatric beds blocked by patients awaiting transfer to their local psychiatric unit. Bed blocking and delayed discharges can therefore affect many specialties either directly or indirectly.

Our department uses a multidisciplinary team to identify potential problems with discharge soon after patients' arrival. This team meets each week to discuss all patients in the department. By highlighting potential problems at an early stage we aim to decrease the time spent in an acute hospital bed.

Bed blocking is a problem in all specialties. We are fortunate in having both government funded and privately funded residential accommodation and nursing home facilities which act as an extension of geriatric long term care beds. We wonder if the previous policy of closing long term psychiatric beds without adequate funding for alternative accommodation in the community may have played a part in the present situation.

We are concerned that this problem may become more pronounced when the change in funding for community long term care from the government (Department of Social Security) to local authorities takes place next April.

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Ernest Saunders: diagnostic dilemma

EDITOR,—In passing judgment on the basis of what they have read in the newspapers regarding the medical evidence in Mr Ernest Saunders's appeal Robert Howard and colleagues are guilty of the very accusation they make: of basing definite views on inadequate information.¹ They also lose sight of the fact that the Appeal Court is not a clinical case conference. If that was so the issue of presenile dementia would not have been raised in front of Mr Saunders let alone the world in general.

The case against his deterioration in prison being due to a dementia was well presented by Dr George Perkin, who considered that any decision should be delayed. It was made clear by everyone who gave evidence that the diagnosis was not certain, and in a different situation one would obviously have waited for less equivocal diagnostic evidence. Their lordships no doubt took the view that it was better to be safe than sorry and reduced Mr Saunders's prison term to reflect their concern. Considering that Mr Saunders had already served a prison sentence for a first offence of theft, they thereby eschewed the possibility of him spending further time in penal conditions if in fact his days were so grimly numbered.

Some people seem angry about the case, feeling cheated of their pound of flesh and that Mr Saunders has a duty to deteriorate to provide it. I am sure that Howard and colleagues have no such base motives but are entirely concerned with the credibility of their specialty. Specialties of all sorts, however, need to be put in the human context that prevails in relation to individual cases, and the Appeal Court had the advantage, which Howard and colleagues have not, of weighing the clinical evidence within the wider context of the judicial situation. I am sure that Howard and colleagues will want to join me in expressing pleasure that Mr Saunders is apparently so much better.

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1 Howard R, Levestone S, Levy R. Ernest Saunders: diagnostic dilemma. *BMJ* 1992;304:1568. (13 June.)

Patient's charter in outpatient services

EDITOR,—In his editorial Charles Collins states that specialty outpatient clinics will have to develop a rigid booking pattern to be able to give specific appointment times but does not mention how specialties outside surgery will achieve this with present resources or the loss of the flexibility that allows patients with serious conditions to be seen quickly without admission to a scarce inpatient bed.¹

In oncology, with an open booking system and a varying number of new patients each week, there will inevitably be differences in waiting time, often over the 30 minute target. But the advantages to patients of reducing their waiting time at home and the accompanying anxiety, the early discussion of their diagnosis and treatment plan, and reducing the time to the start of treatment outweigh the wait in the clinic. If patients are informed of the size of the clinic and the reasons for the delay they are almost always sympathetic to the staff's problem. The alternative is ever lengthening outpatient waiting lists and an implicit selection process for treatment based on who has or has not succumbed while on the waiting list.

The editorial mentions a limit of 13 weeks between referral and first outpatient appointment, but again no qualitative weight is added to this. I doubt that a woman presenting with a breast lump or a man with a testicular swelling would consider

such a wait an improvement in the quality of service.

Follow up visits should also be more structured, according to Collins. Certainly the overall number and frequency of visits could be reduced with no loss of quality, but more structuring also leads to loss of flexibility, which impairs local response to changing demands: with more structured clinics it is harder to arrange an appointment at short notice. Both routine follow up and non-routine interval visits are important in detecting recurrence of cancer,² though they may be less important after some surgical procedures.³

As with much of the present reform in the NHS, the end points indicating quality of care that are harder to measure are being sacrificed for those that are easier to measure, such as outpatient waiting times, which are often less relevant to patients' overall satisfaction, utility, and outcome.

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EDITOR,—Charles Collins's editorial on organising outpatient services to comply with the patient's charter proposes guidelines for consultation times in surgical outpatient clinics and states that efficient referral patterns may obviate the need for some outpatient attendances.¹

In 1990 I reviewed all patients admitted to Sandwell District General Hospital for hernia repair during 1989 to audit assessment of patients' fitness for anaesthesia as detailed in the notes and to propose a standardised referral letter for patients with a hernia, including a questionnaire designed to identify those with potential problems regarding anaesthesia. The proposed questionnaire asked for a brief history of cardiac and respiratory disease and diabetes; current drug treatment; recent blood pressure and pulse rate; and results of analysis of urine. These details would require little extra time to provide on referral, particularly if practice records were computerised.

A total of 269 patients were reviewed. Problems of potential relevance to anaesthesia or general postoperative care were identified in 74 patients. Problems were documented in the note of the initial outpatient consultation for 40 of these patients, and for only 37 of the 70 patients referred by general practitioners (four patients were internal referrals) was a problem identified in the referral letter. The questionnaire would have identified all but two of these problems (table); an outpatient visit would be unlikely to have identified the two other problems (one heart murmur, one acute chest infection). Six operations were cancelled during the year, including those for the patients with a heart murmur and acute chest infection; the four other problems would have been identified

Problems identified by proposed questionnaire

Problem	No	Cancelled operations
Hypertension	33	2*
Cardiac disease	13	3†
Chronic airway disease	15	1‡
Asthma	5	
Diabetes	5	
Oral contraception	1	
Thyrototoxicosis	1	
Steroid treatment	1	
Total	74	

Operations cancelled because of *uncontrolled hypertension; †atrial fibrillation, congestive cardiac failure, and heart murmur; ‡acute exacerbation.