to angiographically proved severe stenosis or occlusion of the internal carotid artery, resulting in a frequency of stroke due to disease of the internal carotid artery of only 5.5%. Secondly, Irvine and colleagues assert that "the great majority [of ischaemic strokes] occur in patients with asymptomatic carotid artery disease," which is contrary to data from other stroke series.³ The prevalence of haemodynamically important extracranial internal carotid artery stenosis is low (7% in women and 9% in men when measured by Doppler ultrasonography in the Framingham population⁴), and the annual rate of stroke in people with internal carotid artery stenosis of $\geq 60\%$ in the asymptomatic carotid atherosclerosis study was only 2%.⁵ By contrast, non-valvar atrial fibrillation shows a gradual increase in prevalence with advancing age, with 21.3% of strokes directly attributable to atrial fibrillation occurring at ages 70-79 and 36.2% at ages 80-89. With an average annual stroke rate of 5%, atrial fibrillation is a more powerful risk factor and a more common cause of ischaemic stroke than extracranial internal carotid artery stenosis.

When trying to decide about the value of carotid endarterectomy in asymptomatic patients the important question is: what proportion of patients with asymptomatic internal carotid artery stenosis develop a major ipsilateral ischaemic stroke without warning transient ischaemic attacks? The North American symptomatic carotid endarterectomy trial showed that patients with transient ischaemic attacks and an internal carotid artery stenosis of $\geq 70\%$ have a 65% reduction in the risk of ipsilateral stroke and an 81% reduction in the risk of major or fatal ipsilateral stroke with carotid endarterectomy. It is therefore essential to know the number of patients in the medical arm of the asymptomatic carotid atherosclerosis study whose major ipsilateral stroke occurred without an antecedent transient ischaemic attack, as these patients are the ones likely to benefit from prophylactic endarterectomy. A comparison of the frequency of stroke without antecedent transient ischaemic attack with the frequency of stroke and death resulting from carotid angiography and endarterectomy should indicate the value of the procedure in asymptomatic patients.

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Resuscitation charts should be used in paediatric care

EDITOR,—James Stuart is correct in highlighting the difficulty of calculating the dose of adrenaline needed for resuscitation in a child with acute anaphylaxis.¹ Indeed, because of the variation in weight for age, this problem applies to all drugs that are given in paediatric resuscitation. The Oakley resuscitation chart was designed to over-

come the problem by allowing users to use a child's age, weight, or length (an easily measured variable) to determine the required doses of drugs.² Burke and Bowden have published a new chart that states the quantity of drug in millilitres rather than milligrams, so avoiding errors in calculation.³

Every doctor who may be involved in paediatric care should carry one of these pocket sized charts so that drug doses may be rapidly and safely determined during the stress of resuscitation.

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Attitude of consultant physicians to Calman proposals

Anxieties are widespread

EDITOR,—We would like to reply to some of the letters relating to our questionnaire survey on the attitudes of consultant physicians to the Calman proposals.¹

We are reassured by J N Johnson's response, in which he states that "emergency services were never intended to be routinely provided by resident consultants" and that the BMA "would vigorously oppose such a proposal."² This is an important statement. It is directly contrary to the recommendations of the Committee of Postgraduate Medical Deans and the UK Conference of Postgraduate Deans in their provocative paper on training for senior house officers, in which it is stated that "all Trusts will need robust arrangements for providing consultant managed quality care for emergency and acute admissions throughout the 24 hours."³ The document also states that "some consultants who have not been actively involved in providing emergency care for some time may need special training." John G Temple, the chairman of the UK Conference of Postgraduate Deans, denies that this implies "front line 24 hour cover,"⁴ but the document seems to contradict him. It was this report, rather than the Calman proposals themselves, that initially prompted our survey. Perhaps we should not have taken it so seriously, but it carried the endorsement of the postgraduate deans, who are the principal group charged with implementing these reforms. Have they now reconsidered their view?

David London admits that the Calman reforms will lead to a reduction in contact time between patients and doctors. Is this a formula for improved patient care? The increase in the numbers of middle grade staff reputedly recommended by the Specialist Workforce Advisory Group and the provision of transitional funding are obviously welcome, but the shorter total length of training and the increased educational component, combined with the effects of the new deal, will certainly reduce the service input. The overriding issue of who will make up the shortfall has not been adequately addressed. Everyone supports measures to improve standards of training, but these should not occur at the expense of services to patients.

London objects to our assertion that the Royal College of Physicians has made no attempt to ascertain the views of consultant physicians. Perhaps we should have used the word "little" rather than "no." Many colleagues, however, are

distinctly uneasy about the proposals and their consequences and consider that neither the BMA nor the college should have given even qualified approval to them before consulting the consultant body as a whole.

Our paper has shown widespread and hitherto unrecognised anxieties among consultant physicians about the proposals and their effects on services, which require careful consideration. Successful implementation may otherwise prove difficult.

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Who is responsible for quality of acute medical care?

EDITOR,—The attitudes of consultant physicians to the Calman proposals provide important information about the organisation of acute medical care in Britain.¹ Recently, in response to such audits as the national confidential enquiry into perioperative deaths and the confidential enquiry into maternal deaths, many acute specialties have seen an increase in consultants' involvement in emergency care. General medical practice has escaped such scrutiny, and this together with the tendency to subspecialisation has apparently led to a system in which trainees provide most acute medical emergency care. Many of these trainees are relatively inexperienced, and as junior doctors' hours have been progressively reduced their opportunities for gaining experience and practical skills have diminished.

We have recently completed a confidential inquiry into the quality of care before admission to an intensive therapy unit. In this twin centre study (in Portsmouth and Southampton) 51 of 100 adults admitted as an emergency were medical patients, of whom 38 were not seen by a consultant physician in the 24 hours before admission to the unit. Thirty medical patients were attended solely by a doctor of registrar grade or below. Furthermore, 11 of the medical patients were managed by junior trainees without postgraduate qualifications. External independent assessors concluded that at least 24 medical patients had received substandard care before admission to the unit.

The conclusions of the national confidential enquiry into perioperative deaths and the confidential enquiry into maternal deaths have emphasised that senior staff should be actively involved in the management of emergencies. It is interesting, therefore, that most consultant physicians (80%) think that greater consultant involvement is likely to be detrimental to patient care.¹ This probably reflects the fact that many of them provide high quality subspecialty services such as gastroenterology and endocrinology. If, however, consultant physicians' involvement would worsen acute medical care and 70% of consultant physicians have not inserted a central line in the past five years, who has been responsible for training and supervising junior medical doctors and who is responsible for the quality of acute medical care?