now performed in all cases in which the diagnosis is suspected. Where measles remains endemic, laboratories should review their use of the complement fixation test for screening and use the serum IgM test to provide rapid results, at least until a salivary IgM test is more widely available.

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Training in advanced trauma life support

All aspects of life support should be part of undergraduate curriculum

EDITOR,—A J Price and G Hughes remind us of the inadequacy of training in resuscitating patients with trauma for senior house officers in Britain.¹ However, all aspects of resuscitation skills, including cardiac and paediatric life support, are sadly lacking. The authors' proposed solution—of increasing training in trauma life support for senior house officers in accident and emergency early in their career—is surely the wrong answer. Advanced life support skills should be a mandatory part of the undergraduate curriculum, with doctors graduating with not only an MB, BS (or equivalent) but also a certificate of competence in advanced life support.

At present many of these skills are taught during courses on paediatric, cardiac, and trauma life support. Doctors in accident and emergency, anaesthetics, and other acute specialties invariably attend each of these, often as late in their career as at senior registrar or consultant level. The content of these courses is similar in the initial stages—that is, demonstration and learning of basic life support techniques, manoeuvres to control an airway, and skills to ensure intravenous access and administration of drugs—with specialty components added and integrated according to the title of the course. The problem of recertification and confirmed maintenance of skills has been inadequately addressed.

If resources from departments of anaesthesia, accident and emergency medicine, general surgery, orthopaedics, paediatrics, cardiology, and general medicine were pooled it would surely be possible to ensure a course that was adequately taught and examined. Table 1 shows a possible timetable. Conceivably a body such as the Resuscitation Council could be commissioned to produce an appropriate curriculum and manual and a body such as the General Medical Council to oversee the examination standards. This course would result in undergraduates being competent in all aspects of resuscitation when they begin their preregistration

posts. It could also be extended to become a mandatory part of registration for overseas doctors, again ensuring common standards of emergency care.

Such a course would lead to better and more cost effective postgraduate training. The royal colleges or whoever oversees relevant specialty training would be able to devise one day refresher courses and assessment at intervals of three to five years as part of formal continuing medical training. Failure to pass this one day course would lead to postgraduate doctors having to fund a full refresher course themselves, which would ensure pressure to maintain skills at an adequate level.

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Go on a course in the United States

EDITOR,—A J Price and G Hughes are right to criticise the difficulty that senior house officers encounter in obtaining training in advanced trauma life support.¹ We suggest that those doctors who have not been able to secure a place on one of the British courses should follow our example and take a course in the United States. There are more than 100 courses all over the country, and with almost no waiting list. A comprehensive list of courses can be obtained from the Committee on Trauma at the American College of Surgeons, 55 East Erie Street, Chicago, IL 60611-2797, USA. The cost of the course is about two thirds the cost of its British equivalent and should be reimbursed with consultant approval, but applicants will have to pay for their travel and accommodation.

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Increased mortality related to asthma among asthmatic patients using major tranquillisers

Underlying ill health is the main risk factor

EDITOR,—The paper by K S Joseph and colleagues seems to imply, in both its title and its conclusions, that there is a causal relation between taking major tranquillisers and death from asthma in asthmatic patients.¹ The results of their study do not support such a causal relation but do show an association. The authors recommend that physicians who treat asthmatic patients with a history of use of major tranquillisers should exercise greater caution over their management. This may be true, and the

authors give a convincing argument to support their case. In reality, however, if general practitioners (who treat most patients with asthma) were to use only the taking of major tranquillisers as a surrogate marker for potential death or near death they would probably miss many patients at risk.

Risk factors for death from asthma have been the focus of research, and much has been learnt from many studies, including those from Cardiff,² the west midlands and Merseyside,³ and the asthma mortality task force,⁴ and from a workshop in Denver, Colorado.⁵ The report on the workshop is particularly helpful as it categorises the findings as factors in medical care, factors related to the patient, and high risk criteria in asthma. The high risk criteria in asthma include particularly adolescence and young adulthood, underlying severe disease, and previous severe attacks. Other risk factors include recent discharge from hospital, poor self care, non-compliance, depression or severe emotional disturbance, and psychosocial factors.

It is psychosocial factors that are often brought to the attention of the primary care team; they affect many more patients than just those who take major tranquillisers. Such factors include family dysfunction, bereavement, separation, alcohol or drug misuse, low social economic status, non-attendance at health care clinics, anger and conflict with doctors or health care workers, poor self care, unemployment, and geographical relocation leading to discontinuity of medical care. It is more important, therefore, that physicians should consider the underlying ill health—be it clinical, social, psychological, or psychiatric—and not its therapeutic management in identifying patients at risk of death from asthma.

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Smoking may increase mortality when patients stop using tranquillisers

EDITOR,—K S Joseph and colleagues report an increased risk of death or near death in asthmatic patients who use major tranquillisers.¹ Their finding that subjects who had stopped taking major tranquillisers in the previous two months were at particularly high risk is intriguing. I am disappointed, however, that the authors do not give data on smoking patterns in the cases and the controls. It is well known that psychotic illness is associated with heavy smoking.² I wonder whether the findings would remain significant after adjustment for differences in smoking habit. It has been suggested that smoking helps schizophrenic patients to cope with psychotic symptoms³ and that smoking improves cognitive deficits.⁴ This raises the possibility that stopping major tranquillisers results in an increase in smoking. Cigarette smoking may therefore be the mechanism that mediates the increased mortality from asthma in those patients who stop using major tranquillisers.

From a practical point of view, in addition to optimising the management of asthma in schizophrenic patients it may be important to place emphasis on helping this vulnerable group of

Table 1—Possible timetable for training undergraduates in life support

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Introduction to basic life support	Practicals in gaining intravenous access	Practical cardiac scenarios	Practical trauma scenarios	Practical paediatric scenarios
Afternoon	Practicals in airway care	Lectures on theory of cardiac arrest	Lectures on theory of trauma	Lectures on theory of paediatric life support	Assessment and examination