cases, which do not necessitate admission to hospital, will generally occur in babies aged 3 months or more, born at term, who are feeding well and whose respiratory rate is <50 breaths/min. Moderate cases necessitate admission to hospital or at least management at home with small, frequent feeds and frequent observations. In these cases the babies are tachypnoeic (50-70 breaths/min), with only slight difficulty with feeds. In severe cases the babies are highly tachypnoeic (>70 breaths/min) or have apnoea, do not feed well, and need urgent admission. Clinical predictors of severity are tachypnoea (>70 breaths/min), age less than 3 months, preterm delivery (particularly before 34 weeks), and an "ill" or "toxic" appearance.²¹ Babies with difficulty in feeding or apnoea should be admitted, and it is probably wise to admit babies with underlying heart, lung, or immune problems who develop bronchiolitis. Cyanosis is a late and sinister sign.

Pulse oximetry, if available, is the best predictor of the severity of the disease and need for oxygen.^{21 22} Given its valuable role in assessing children with bronchiolitis and, to a lesser extent, other respiratory diseases, general practitioners should strongly consider buying a pulse oximeter. The mortality associated with bronchiolitis is low, but babies can deteriorate rapidly and clinical skills are necessary to reduce the mortality and morbidity still further.

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Growing pressure on *BMJ's* obituaries

Something will have to give

Our obituary pages are experiencing growing pressure for the simple reason that the number of British doctors has more than doubled in the past 45 years. In 1950 there were just under 70 000; now there are more than 140 000. Unlike in any other part of the *BMJ*, in the obituaries section we accept everything that is submitted to us—provided that it arrives within our time limit of three months and we have not received any other submission on the person who has died. But we are unlikely to be able to sustain this policy indefinitely, and we welcome readers' ideas on how we might change.

We publish obituaries on about 400 doctors annually, which must be less than half of the British doctors who die each year. We commission obituaries of the famous, which amount to one or two a month; we simply wait for obituaries on other doctors to arrive. The form of the obituary (whether or not the biographical details appear in italic after the main body of the text) is determined simply by the amount of information we are given: with many obituaries almost nothing would be left if we extracted the straightforward biographical details for the final paragraph. Most obituaries are published in the order we receive them, and sadly there is a delay of about three months (meaning that obituaries appear on average about five months after the death).

The pressure on our obituary pages has been increasing for many years, and in 1992 we undertook a survey of 1080 readers to ask how we should respond. Almost half (49%) responded, and they were strongly against us selecting obituaries for publication on the grounds of fame or interest and rejecting the rest. Most didn't want us to increase

the number of pages we devote to obituaries, but they did recognise our problem and suggested that we shorten obituaries further and reduce our time limit. We adopted both these suggestions but have a more generous time limit—three months—than our respondents recommended.

But still our obituaries present us with problems. One of the most unpleasant parts of our job is to have to talk or write to bereaved people who have submitted obituaries after the three month limit. About 45 obituaries a year are submitted late, and about a third of authors appeal against our decision not to publish. We always say "no" because to say "yes" would be unfair on those who missed the time limit and therefore did not submit anything and on those who accepted our decision not to publish without appealing. We would find it invidious to have to decide which deaths were the saddest and which excuses for late submission the best.

A second problem with our obituaries is that many are dull, reflecting only the successes in the lives of those who have died. Most of the doctors whose obituaries appear in our pages seem to have been saints, whereas all doctors have light and shade in their lives. Sadly, medicine does not any more have a culture of "telling it like it is" in obituaries—but it would be good to start one. One strategy we adopted in the hope it would lead to more interesting obituaries was to ask people to write their own: people would surely, we thought, have insight into their own deficiencies and failures. Sometimes, but not often, this strategy has been successful. Archie Cochrane, the famous epidemiologist, wrote probably our best self written obituary: "In 1957 he survived a professor of

surgery's prognosis that he had only three months to live. He was not a real success as a professor, either as a teacher or on the senate, though his kindness to students was proverbial. He was a man with severe porphyria who smoked too much and was without the consolation of a wife, a religious belief, or a merit award—but he didn't do so badly."²

Eventually we may need a radical solution. The *Lancet*, for instance, has abolished obituaries. A supplement might be a solution but would be expensive. The most likely answer is that some day we will switch to publishing death notices

rather than obituaries for most doctors. The advantages would be that we would probably record the deaths of more people than we do at the moment—and more quickly.

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Emergency care in general practice

Doctors need to maintain their knowledge and skills and carry the right equipment and drugs

Life threatening emergencies do not occur every day in general practice: some conditions such as anaphylactic shock may occur only a few times in a professional lifetime. Rarity makes the task of keeping up to date a challenge. How should general practitioners respond?

Firstly, the use of protocols—regularly discussed and updated—should help maintain the essential knowledge. Secondly, regular attendance at practical courses helps sustain skills. The Royal College of General Practitioners has taken an important step by making it a requirement that candidates show their competence at cardiopulmonary resuscitation before they can pass the MRCGP examination. Nevertheless, more skills based courses are needed for established principals.

Thirdly, general practitioners need to be properly equipped for emergency care. The traditional black bag should now be accompanied by a range of items, which may include a nebuliser, intravenous fluids, an electrocardiograph machine, and a defibrillator. While a nebuliser (or large volume spacer) is essential for the successful management of acute severe asthma,¹ the need for the other items is more debatable. For example, when visiting a patient with suspected myocardial infarction a general practitioner might waste precious time by performing electrocardiography. Higher priorities are to arrange urgent admission to hospital, to give adequate pain relief, and to administer aspirin (when appropriate). Nevertheless, there are circumstances in which an electrocardiograph machine might come in useful—for example, in recording a cardiac arrhythmia.

A defibrillator may be life saving in a patient with ventricular fibrillation, and studies have confirmed the value of automated external defibrillation outside hospital.^{2,3} Defibrillators carried by general practitioners are known to be effective⁴; the earlier defibrillation is performed after cardiac arrest the better the outcome.^{2,3} While first line ambulances can provide a rapid response in many cases of cardiac arrest there will be situations in which general practitioners can save lives if they are first on the scene with a defibrillator. The decision to carry this equipment will be influenced by local ambulance response times and provision of appropriate training. Reimbursement of equipment costs would help general practitioners to purchase defibrillators.

Next, general practitioners must carry a suitable range of drugs for the emergencies they are likely to face.⁵ Recent attention has concentrated on aspirin and penicillin. In a questionnaire survey two fifths of general practitioners reported that they did not carry aspirin⁶—yet this drug

reduces the death rate in myocardial infarction if given in the first 24 hours.⁷ It makes sense for general practitioners to give aspirin in suspected myocardial infarction as this will help to ensure that all suitable patients are given the benefits of this drug. In a study by Colbridge *et al* nearly a fifth of general practitioners from the north west of England did not carry benzylpenicillin (p 29)⁸—yet this drug should be given immediately to patients suspected of meningococcal infection.⁹ These results suggest that a substantial minority of doctors need urgently to review the drugs they carry.

Drugs for use in emergencies should be checked regularly to ensure that they have not passed their expiry date. Controlled drugs should be stored in a locked bag, and a careful record should be kept of their use. Another issue is the temperature at which emergency drugs are kept.^{10,11} For example, the datasheet for benzylpenicillin recommends storage below 25°C.¹² The internal temperature of a traditional black bag can reach 40°C in the boot of a car.¹⁰ One cannot assume that the drug will remain active until its expiry date if the recommended storage temperature is exceeded.¹¹ Options for storage include keeping drugs in cool conditions out of the car except when on visits, spraying a black emergency bag silver,¹⁰ or using a "cool bag."

Emergency care in general practice is important. All general practitioners should examine this aspect of their work to ensure they can deliver a high quality emergency service.

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