Purchasers with funds for health promotion should ask for better evidence of the effectiveness of exercise promotion in primary care before parting with a penny.

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Auditing absence due to sickness

EDITOR,—Martin McKee and colleagues highlight some difficulties with the use of routine data for audit and refer to experience in obstetrics.¹ In occupational health practice we have encountered similar problems in setting up a system to audit absence attributed to sickness. Certificates for absences due to sickness of more than seven days are obtained by employees from general practitioners and usually forwarded to the employer's personnel or finance department. For self certified spells of illness of shorter duration the information about the reason for illness tends to be vague. Not all certificates find their way to the occupational health department.

To audit how such episodes of absence due to sickness are managed it is necessary to determine their causes and the extent to which they contribute to time lost. Trying to code the diagnosis written on the Med 3 forms is difficult without an agreed system. We have considered using the *International Statistical Classification of Diseases and Related Health Problems* (10th revision) and the Read codes (with several thousand codes)² to categorise causes of absence. These have been found to be too complicated for routine collation of data on absence due to sickness.

One option is to develop a separate, simplified coding system for use in an occupational health setting. Ideally this would be a computer based system that was easy to use and allowed data to be entered by clerical staff. The civil service's occupational health service has developed a coding system that is used internally.³ It has the support of staff familiar with the coding, who can be contacted via a dedicated telephone line.

We are piloting a prototype simplified coding system for data on absence due to sickness that can be used by an occupational health service. The main attraction of this system is that it has fewer than 100 categories, which cover the main certified causes of absence in industry. It is simple enough to be used by small occupational health departments yet has sufficient detail to allow trends in different causes of absence to be analysed. The system is also being considered for use in an audit of absence attributed to sickness in the NHS. If use of the system is successful this could lead to a

standardised instrument for auditing, comparing, and managing absence due to sickness in different occupational settings.

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Biological washing powders as allergens

EDITOR,—A paper by me¹ is cited by P J Rees in the reply to a query on whether biological washing powders might be a new allergen.² Rees states that I reported late onset asthma in workers in factories producing these powders. In fact, the proteolytic enzyme was found to be a potent respiratory sensitizer, causing immediate and late asthma mediated by IgE in both atopic and non-atopic subjects, few of whom had had asthma previously. Sensitisation and symptoms associated with enzymes can occur in laboratory and office workers, and the material was no more visible in the general workplace than house mite allergen is in a domestic setting.

Later, a worker who was sensitised to the enzyme was admitted to hospital with severe asthma, which stopped when he was no longer exposed to the enzyme. There were two recurrences: once when he wore clothes that, unknown to him, had been washed in biological detergent; and once after the floor of his otherwise enzyme free workplace had been washed, without his knowledge, with a biological detergent solution.

Thus, although precautionary encapsulation of the enzyme powder appreciably reduced the incidence of sensitisation and asthma in people involved in its manufacture and lessened domestic airborne contamination, continual use of liquid or powder enzyme preparations cannot be assumed to be free of risk. Apart from the possibility of invisible dust occurring from powders and xeromists occurring from liquid preparations or powders in solution, the allergen will persist in garments, bedclothes, and carpets washed or cleaned with detergents containing the enzyme. The build up of allergen in the domestic environment will increase with continued use.

A capacity to give rise to sensitisation is not confined to enzymes that are proteolytic.³ These enzymes seem to be sensitizers by virtue of being high molecular weight proteins, irrespective of their specific activity.⁴ Thus lipases, or other enzymes in the new detergents, share the potential for sensitisation of the original preparations.

Known allergens must not be overlooked when sources of an increased incidence of asthma are sought, and it is particularly unfortunate when patients are symptomatically treated for asthma while they continue knowingly to be exposed to a specific allergen. This often happens when the source is occupational¹ and may have fatal consequences.⁵

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Resuscitation skills of MRCP candidates: one year on

EDITOR,—In June 1993 we reported on the quality of the resuscitation skills of 30 candidates taking the second part of the membership of the Royal College of Physicians (MRCP).¹ Their knowledge of the then current Resuscitation Council guidelines for managing cardiac arrest was lacking. We concluded that this was probably the result of poor resuscitation training in medical schools and their current places of work.¹

A year later we repeated the assessment on 31 candidates preparing for the same examination. A similar format of assessment was used. Each candidate was asked to run a simulated cardiac arrest. They were asked to treat a "patient" (model) showing both ventricular fibrillation and one other rhythm of cardiac arrest on the defibrillator monitor. They had appropriate equipment, drugs, and staff available if required.

Resuscitation skills fell short of a satisfactory standard. Most candidates were unfamiliar with the 1992 Resuscitation Council guidelines for managing cardiac arrest. Drug treatment was inappropriate and defibrillation treatment unsafe. We found that eight of the 31 candidates on the course ran a simulated cardiac arrest in an acceptable manner. Eighteen of the candidates went on to pass their examination.

There have been many publications on the poor resuscitation skills of medical and nursing staff. Furthermore, the skills that are acquired are notoriously badly retained. Twenty seven of our 31 candidates said that they had received resuscitation training in their hospital. In 1987 the Royal College of Physicians published its recommendations for the content and organisation of resuscitation training in hospital.² It stated that each hospital should appoint a resuscitation training officer whose sole job it should be to train all members of hospital staff to an appropriate level of skill in resuscitating a patient in cardiac or respiratory arrest. They stipulated that medical staff should have regular training that incorporated simulated cardiac arrests. Training programmes should be implemented through the resuscitation training officer, medical schools, and postgraduate training centres.

We think that the importance of proficiency in managing resuscitation gained by regular training would be emphasised more strongly if proficiency were a prerequisite for all postgraduate medical examinations. An example of this has been set by the Royal College of General Practitioners: candidates may sit its examination only if they have a current certificate of competence in life support.

With this incentive coupled with increased availability of resuscitation training and with adequate time allocated to training, medical staff's currently unacceptable working knowledge of resuscitation procedures would be improved.

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