

and a defibrillator as well as my medical bag up five flights of stairs in a block of flats, where the lift is invariably out of order or its floor swimming in urine? What do I do with the equipment while visiting patients who do not require it? If I leave it in the car the possibility of its being stolen is high. Have the authors considered the practical implications of their advice?

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1 Avery A, Pringle M. Emergency care in general practice. *BMJ* 1995;310:6. (7 January.)

### Should be properly recognised

EDITOR,—The editorial on emergency care in general practice fails to mention the growing trend for many general practitioners not to provide prehospital emergency care for their patients—for example, emergency coronary care or care in asthma.<sup>1</sup> Other health care professionals, such as those in the ambulance service and midwives, are only too keen to take on this work to enhance their status. It is surely in the best interests of neither our patients nor the medical profession as a whole for us to lose, by default, what is an integral and rewarding part of general practice. The provision of effective emergency care requires proper contractual recognition, reward, training, equipment, and drugs.

We are surprised at the authors' suggestion that general practitioners should not waste time obtaining an electrocardiogram in patients with a suspected acute myocardial infarction and at their failure to mention thrombolysis before admission to hospital. The risk of developing a potential lethal cardiac arrhythmia is greatest immediately after the onset of infarction,<sup>2</sup> and all patients with a suspected acute myocardial infarction should be monitored electrocardiographically before and during transportation to hospital. It has been shown that the earlier a thrombolytic drug is given the greater the benefit,<sup>3</sup> although this is controversial; the British Heart Foundation's latest guidelines recommend that a thrombolytic drug should be given before admission if the likely time from the initial symptoms to thrombolysis being given in hospital is more than 90 minutes.<sup>4</sup>

Perhaps the time has come when all aspects of prehospital emergency care, including the mechanisms for the most effective delivery of that care, need re-evaluation.

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1 Avery A, Pringle M. Emergency care in general practice. *BMJ* 1995;310:6. (7 January.)

2 Armstrong A, Duncan B, Oliver MF, Julian DG, Donald KW, Fulton M, et al. Natural history of acute coronary heart attacks. A community study. *Br Heart J* 1972;34:67-80.

3 GREAT Group. Feasibility, safety, and efficacy of domiciliary thrombolysis by general practitioners: Grampian region early trial. *BMJ* 1992;305:548-53.

4 Weston CFM, Penny WJ, Julian DG, on behalf of the British Heart Foundation Working Group. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994;308:767-71.

### Irish general practitioners learn immediate cardiac care

EDITOR,—We agree with Anthony Avery and Mike Pringle that more courses on emergency care should be provided for established principals in general practice.<sup>1</sup> For the past two years we, in conjunction with the Irish College of General Practitioners, have been providing courses in

immediate cardiac care locally to Irish general practitioners. A local tutor from the college's continuing medical education faculty organises the administrative details (venue, facilities, catering, etc), and we provide the tutors and teaching equipment. The content of the courses is based on the recommendations of the American Heart Association<sup>2</sup> but is limited to prehospital concepts (for example, lignocaine is the only antiarrhythmic drug reviewed). A good ratio of tutors to participants—usually 1:4—is an essential part of the skills training in the course. The skills stations teach cardiopulmonary resuscitation, management of the airway, management of arrhythmias, and management of the cervical spine in cases of trauma. Finally, each participant, in conjunction with local ambulance staff, puts all these skills together during a simulated arrest.

To date, 235 practitioners—almost one eighth of all principals in general practice in the Republic of Ireland—have participated. Four fifths of participants have completed feedback forms; all described the course 'as useful or very useful'. The small group format, skills based components, and opportunity to practise with local ambulance crews have been especially appreciated. The original core group of three tutors has now expanded to 15. Most are principals in general practice, but a nursing tutor and ambulance service tutor also participate. All are trained in advanced cardiac life support to the American Heart Association's standard. Owing to the popularity of the course a similar course in immediate trauma care is now also being provided.

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1 Avery A, Pringle M. Emergency care in general practice. *BMJ* 1995;310:6. (7 January.)

2 American Heart Association. *Advanced cardiac life support: instructor's manual*. Dallas: AHA, 1994.

### Courses are available

EDITOR,—Anthony Avery and Mike Pringle emphasise the importance of emergency care in general practice.<sup>1</sup> I commend to readers the certificate course in prehospital emergency care run jointly by the Royal College of Surgeons of Edinburgh and the British Association for Immediate Care (BASICS). The first course was held in March 1993. I recently attended one of these three day courses and found it an ideal way of updating and advancing my knowledge and practical skills in emergency care (trauma, medical, paediatric, obstetric); there was the added benefit of meeting the other participants (doctors, paramedics, and nurses). The course ends with a formal assessment. For further details of this course and other more advanced training by BASICS, readers should write to Dr J Scott, BASICS Education, 34A Woollards Lane, Great Shelford, Cambridge CB2 5LZ.

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### General practitioners should be trained in cardiopulmonary resuscitation

EDITOR,—Anthony Avery and Mike Pringle's recommendations regarding emergency care in general practice are useful, but we cannot visualise

every general practitioner carrying a defibrillator, as well as all the other items mentioned, while doing his or her home visits.<sup>1</sup>

As anaesthetists, we are constantly appalled at the lack of basic resuscitation skills of medical and nursing staff (senior and junior). Management of the airway is something in which everyone seems to fail horribly. If these findings are extended into general practice the management would be even worse as general practitioners see few collapsed patients. We believe that the Royal College of General Practitioners should alter the training programmes for general practice to include at least three months in anaesthetics. This could perhaps be incorporated with three months in acute trauma (orthopaedics). As Avery and Pringle mentioned, regular updates are extremely important in maintaining skills.

Recently we wrote to all our local general practitioners about the availability of training in cardiopulmonary resuscitation in our hospital. We extended this invitation to their nurses and receptionists. Nine months later the only response has been one telephone call. We believe that local tutors in general practice should encourage their fellow doctors constantly to improve the quality of service they provide to the local population; as well as cervical smear tests and well women clinics, constant updates in cardiopulmonary resuscitation should be essential.

This in no way is meant as a criticism of general practitioners, but in the present medicolegal climate we should all attempt to improve the care we provide to our patients.

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### Antibiotics carried in general practitioners' emergency bags

#### Having a central supplier would increase carriage of drugs

EDITOR,—As part of a course for a diploma in therapeutics I carried out a survey of the drugs carried by general practitioners in 1994. I sent a questionnaire to all 304 course members, who were general practitioners in the areas covered by North Tyneside and Northumberland Family Health Services Authorities, asking about drugs and equipment carried; 193 questionnaires were completed in respect of antibiotics.

Interesting differences are evident between my findings and those of M J Colbridge and colleagues<sup>1</sup> and Ong and Dunbar<sup>2</sup> (table). Over the past six years carriage of ampicillin has fallen dramatically and that of co-trimoxazole and tetracycline less so. Carriage of amoxycillin and co-amoxiclav and of trimethoprim has risen. Carriage of benzylpenicillin has increased to 95%.

Just before Ong and Dunbar's survey in 1988 the chief medical officer advised all doctors to give parenteral benzylpenicillin before admitting to hospital any patient suspected of having meningococcal infection.<sup>3</sup> To encourage doctors to carry benzylpenicillin general practitioners in the areas covered by North Tyneside, Northumberland, and Newcastle Family Health Services Authorities were supplied with free phials of benzylpenicillin. The availability of a free supply of samples and single dose sachets of many antibiotics is likely to be a potent factor in the selection of antibiotics for the emergency bag. In the late 1980s Beecham offered a monthly postal service, supplying sachets of ampicillin, and Wellcome similarly offered free