The junior doctors expressed reservations before their first appraisal, but now appear to welcome the opportunity to discuss their careers, any problems with their post, and training needs. The consultants find appraisal a useful way of discussing a doctor's strengths and weaknesses in an objective and non-threatening manner, and in identifying areas where support is needed.

Our next concern is how the consultants should assess themselves. Any ideas?

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*The above mentioned appraisal forms are available on request from Dr Jan Welch, at King's College Hospital, London.

Resuscitation status of the elderly

Sir—The recent article by Drs Smith and Hastie (October 1992, pages 377–9) is an excellent summary of recent work concerning resuscitation of the elderly. While it is well established that patients with severe illness have a poor outcome following cardiopulmonary resuscitation (CPR), I believe the importance of the site and circumstances of the arrest is insufficiently recognised when formulating 'do not resuscitate' policies. Unwitnessed arrests on the general wards have a poor outcome following attempted resuscitation [1–3]. Only one of 108 elderly patients in our study [1] and one of 116 elderly patients in Murphy's study [2] survived to discharge following an arrest which was not witnessed. The delay in initiating resuscitative measures is undoubtedly the most important factor. Patients in coronary care or high-dependency units have a better survival rate, reflecting the closer surveillance of patients and the higher prevalence of ventricular tachyarrhythmias [4]. In contrast, asystole is the most common initial rhythm in patients whose arrest is not witnessed [1].

When patients are found dead in bed during routine rounds by the nurses, attempts at resuscitation only cause distress to the other patients and to the medical and nursing staff. In accordance with the principle that CPR is most suitable for patients with a reasonable chance of survival, I believe there is a case for differential 'do not resuscitate' orders based on the circumstances of the arrest. For some patients, resuscitation is clearly indicated or contraindicated irrespective of whether or not an arrest has been witnessed. For other patients, while it may be reasonable to attempt resuscitation in optimal circumstances, death should not necessarily be equated with 'cardiac arrest'. Our experience in discussing resuscitation with elderly Irish patients in a geriatric unit [5] suggests that such a policy might also be more acceptable to patients.

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Generic substitution

Sir—I note with interest Dr Griffin's article opposing generic substitution (October 1992, pages 388–9). Without getting into the debate on whether generic products are equal or inferior to branded drugs, I wish to point out the recent scare to the American public about an alleged shortage of sublingual nitroglycerin tablets on the market [1]. What the *New York Times* article should have said was that there was a shortage of Nitrostat [2], a brand of nitroglycerin, but not the generic nitroglycerin itself.

The false alarm created by the news media would never have arisen had all the doctors practised generic prescribing, ie, using generic rather than proprietary names on the prescriptions. Furthermore, unless kept in a dark coloured bottle and in a relatively cool environment, even the branded nitroglycerin deteriorates quickly and loses its effectiveness in relieving angina.

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