arrhythmias and hyperkalaemia unrelated to exposure to suxamethonium. Secondly, both hyperkalaemic periodic paralysis and Andersen's syndrome are dominantly inherited, and other family members may be at risk of sudden death. Thirdly, both conditions are amenable to treatment.

PHILIP JARDINE
Consultant paediatric neurologist
Department of Neurology,
Bristol Royal Hospital for Sick Children,
Bristol BS2 8BJ

1 Jackson MA, Lodwick R, Hutchinson SG. Hyperkalaemic cardiac arrest successfully treated with peritoneal dialysis. *BMJ* 1996;312:1289-90. (18 may.)
2 Tawil R, Ptacek LJ, Pavlakis SG, DeVivo DC, Penn AS, Ozdemir D, *et al.* Andersen's syndrome: potassium-sensitive periodic paralysis, ventricular ectopy, and dysmorphic features. *Ann Neurol* 1994;35:326-30.

### May occur secondary to misuse of diuretics and potassium supplements

EDITOR,—M A Jackson and colleagues highlight the difficulties of managing cardiac arrests due to hyperkalaemia.[1] We have recently seen a case similar to theirs; our case was secondary to misuse of diuretics combined with self medication with potassium supplements.

The patient was a 46 year old woman with a history of long term misuse of diuretics and laxatives and documented hypokalaemia. She had recently changed her diuretic of misuse (which she obtained through a friend) from frusemide to co-amilofruse. She presented with a four day history of increasing generalised weakness. Plasma urea and electrolyte concentrations were available immediately after she had a witnessed fit and subsequent cardiac arrest (sodium concentration 125 mmol/l, potassium 8.6 mmol/l, chloride 85 mmol/l, bicarbonate 10 mmol/l, urea 52.8 mmol/l, and creatinine 221 μmol/l). Her rhythm alternated between ventricular fibrillation and pulseless ventricular tachycardia and was resistant to direct current shock, adrenaline, and lignocaine. Cardiopulmonary resuscitation was maintained while the hyperkalaemia was treated with 30 ml of 10% calcium chloride and 25 g of 50% dextrose with 25 units of soluble insulin. Twenty minutes later her plasma potassium concentration had fallen to 6.4 mmol/l and cardioversion occurred. The total duration of cardiopulmonary resuscitation was one hour 15 minutes. She made an immediate neurological recovery. Her renal function returned to normal within the next 72 hours with rehydration alone. She later disclosed that she had taken a substantial amount of a previous supply of potassium supplements, which in the past had successfully treated any weakness due to hypokalaemia.

We wish to emphasise the importance both of prolonged cardiopulmonary resuscitation in hyperkalaemic arrests and of giving calcium chloride to stabilise the myocardium during the time taken to reduce the plasma potassium concentration with glucose and insulin. Diuretic misuse is well recognised[2] and treatment with diuretics common. The dangers of self medication must not be forgotten.

EDWARD STRIVENS
Senior house officer
AYESHA SIDDIQI
Lecturer in endocrinology
RICHARD FLUCK
Lecturer in medicine
ANDREW HUTTON
House officer
DAVID BELL
House officer
Department of General and Emergency Medicine,
Royal London Hospital,
London E1 1BB

## In general practice "registrars" are more likely to be perceived as qualified than are "trainees"

EDITOR,—Last year a major change occurred in the terminology for those undertaking postregistration training in general practice. The term "trainee," which had been used since 1950,[1] was replaced by the term "registrar." It had long been argued that the word "trainee" was derisory,[2] equating as it does with "novice" or "greenhorn," according to *Roget's Thesaurus*.[3] In 1993 a survey showed that fewer than half the patients questioned thought that a trainee was a qualified doctor.[4] It is hoped that the adoption of the new term, registrar, with its more positive connotations of book-keeper, master of the rolls, or intern,[3] will result in patients' perceptions being more positive. Has this occurred?

I undertook a survey in a training practice with five partners. The partners operate individual lists, and a locum has been employed for three sessions a week for the past five months. Consecutive patients attending a general practitioner, registrar, locum, or practice nurse were asked to complete a questionnaire until 100 completed forms had been returned; 123 questionnaires were given out to achieve this. Patients ringed one answer (true, false, or do not know) for each of the statements on the questionnaire. Figure 1 shows the results.

Patients were more likely to consider a registrar in general practice than a trainee in general practice to be a qualified doctor, and this perception greatly influenced the likelihood that patients would be satisfied. Altogether 86% (48/56) of those who thought that a registrar was qualified would be satisfied with his or her advice, compared with only 9% (4/44) of those who thought that a registrar was not qualified ($\chi^2 = 57.97$, $P<0.001$). Similarly, 70% (30/43) of those who thought that a trainee was qualified would be satisfied compared with only 12% (7/57) of those who thought that a trainee was not qualified ($\chi^2 = 34.75$, $P<0.001$).

Clearly, terminology affects perception. There remains room for improving the image of registrars: the practice nurse is still preferred to the registrar. Nevertheless, the change in title is supported. Ultimately, perhaps the best public relations are achieved in practice by ensuring that staff refer to doctors in training by their name and not by their status.

J P FISHER
Registrar in general practice
Albany Surgery,
Newton Abbot TQ12 2TX

1 Horder JP, Swift G. The history of vocational training for general practice. *J R Coll Gen Pract* 1979;29:24-32.
2 Elliot-Binns CP. Why not scrap the word trainee? *J R Coll Gen Pract* 1982;32:504.
3 Kirkpatrick B, ed. *Roget's thesaurus of English words and phrases.* Harmondsworth: Penguin, 1988.
4 Turner C. GP trainees. *Br J Gen Pract* 1993;43:479-80.

## GMC's conduct committee is harsher to British than overseas doctors

EDITOR,—In her editorial about the possibility of racial bias in the General Medical Council's handling of complaints against doctors Fiona Godlee writes: "Of those who reached the professional conduct committee, a higher proportion of British and Irish graduates were eventually struck off. This suggests that complaints against doctors who qualified in Britain or Ireland have to reach a higher threshold of seriousness of misconduct or weight of evidence before they will be referred to the professional conduct committee."[1] I would strongly challenge this.

It is equally arguable that the conduct committee is harsher to English and Irish doctors and more lenient to overseas graduates. This was my experience when I served on the conduct committee, because one went to great lengths to be fair and made full allowance for the fact that overseas doctors were often unfamiliar with the customs and standards of behaviour prevalent in Britain, which sometimes contrasted considerably with those in the country from which the doctors had come. To put it bluntly, the English and Irish doctors knew when they were doing wrong and had to pay the price; overseas graduates were sometimes uncertain and got the benefit of the doubt.

TONY KEABLE-ELLIOTT
General practitioner
Peels,
Ibstone,
High Wycombe HP14 3XX

1 Godlee F. The GMC, racism, and complaints against doctors. *BMJ* 1996;312:1314-5. (25 May.)

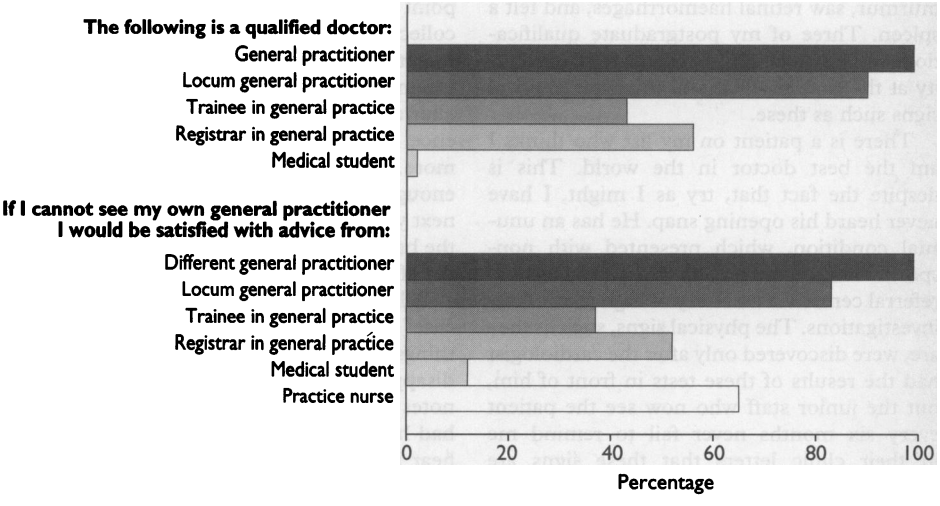


**Fig 1**—*Percentage of patients answering "true" to two questions*