

for trainees to acquire the necessary skills. It remains to be seen if the proficiency in resuscitation skills among those taking anaesthetic examinations is higher than that among candidates taking the examination for membership of the Royal College of Physicians. The resuscitation training officer has a valuable role in ensuring that these skills are retained.

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1 Prior-Willeard PFS, David J. Resuscitation skills of MRCP candidates: one year on. *BMJ* 1995;310:195. (21 January.)

### In future, cardiac arrest teams may require current evidence of their skills

EDITOR,—We agree with P F S Prior-Willeard and J David that resuscitation skills fall short of satisfactory standards, even in those who are members of cardiac arrest teams.<sup>1</sup> A recently completed audit of cardiac arrest procedures at our hospital showed that the guidelines issued by the European Resuscitation Council in 1992<sup>2</sup> were unavailable at 25 of 77 (32% (95% confidence interval 22% to 44%)) cardiac arrest calls. Furthermore, these guidelines were followed in only 55 of 68 (81% (70% to 89%)) cardiac arrests for which they were applicable. We also found that early management of the airway in cardiac arrests was ineffective in 38 of 76 cases (50% (38% to 62%)).

The anaesthetic department in our hospital is leading the way in resuscitation training and is shortly to require each of its members formally to demonstrate proficiency in basic life support. In North America the possession of a certificate confirming skills in basic life support is a prerequisite for employment in many hospitals. The Royal College of Anaesthetists has also set high store by the demonstration of adequate resuscitation skills. A resuscitation station is now a mandatory part of the objective structured clinical examination in the examination for part 3 of the fellowship of the college.

Will we yet see the day in Britain when all members of cardiac arrest teams will be required to possess current certificates confirming their skills in advanced life support?

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1 Prior-Willeard PFS, David J. Resuscitation skills of MRCP candidates: one year on. *BMJ* 1995;310:195. (21 January.)

2 European Resuscitation Council Working Party. Adult advanced cardiac life support: the European Resuscitation Council guidelines 1992 (abridged). *BMJ* 1993;306:1589-93.

### Skills and knowledge should be tested in postgraduate exams

EDITOR,—Recent correspondence has highlighted the deficiencies of various groups attending cardiac arrest.<sup>1,3</sup> We believe that doctors are motivated to practise basic life support skills and learn guidelines on advanced life support mainly when these are required for career advancement. One example of this is the fellowship of the Royal College of Anaesthetists: life support is included in the curriculum for the examination for parts 1 and 3, and candidates know that they will be tested on this subject.

We surveyed 43 anaesthetic trainees in our region by questionnaire to assess their knowledge

### Effect of study for examination on score for knowledge of cardiopulmonary resuscitation and pass rate

Group	No	Median score (interquartile range)	No (%) who passed
1	14	10 (9-11)	9 (65)
2	16	9 (8-11)	3 (19)

of the European Resuscitation Council's advanced cardiac life support guidelines of 1992.<sup>4</sup> Each trainee could score a maximum of 13, and a pass was awarded if intravenous access and intubation were attempted at the appropriate time, the correct energy level and sequence of DC shocks were indicated, the correct number of sequences of cardiopulmonary resuscitation was known, and drugs were used with appropriate doses and timing.

The overall median score was 9, and 15 trainees passed. Senior house officers (n=22) scored significantly better than senior registrars (n=13) (median score for senior house officers, 10; median for senior registrars, 7; P=0.01). The effect of study for examinations was assessed by looking at senior house officers and registrars. Group 1 (n=14) had successfully passed part 1 or 3 of the fellowship of the Royal College of Anaesthetists in the previous year, while group 2 (n=16) had not. Group 1 had a significantly higher pass rate (P<0.05), but scores were similar.

In this small sample of anaesthetists we have shown that a pass in an examination is not enough to equip them for the rest of their careers. Similar shortcomings have been shown in other groups.<sup>1,2</sup> If the general standard of resuscitation is to be improved we agree with other correspondents<sup>3</sup> that leaders of cardiac arrest teams should be certified providers of life support techniques. We also believe that life support skills and knowledge should be tested as part of the postgraduate examinations of all the acute specialties and that other motivation is needed beyond this, such as competence on regular testing as a condition for employment at all grades in these specialties.

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1 Tham KY, Evans RJ, Rubython EJ, Kinnaird TD. Management of ventricular fibrillation by doctors in cardiac arrest teams. *BMJ* 1994;309:1408-9. (12 November.)

2 Prior-Willeard PFS, David J. Resuscitation skills of MRCP candidates: one year on. *BMJ* 1995;310:195. (21 January.)

3 Cook TM, Handel J. Management of ventricular fibrillation by cardiac arrest teams. *BMJ* 1995;310:466. (18 February.)

4 European Resuscitation Council. Adult advanced cardiac life support: the European Resuscitation Council guidelines 1992 (abridged). *BMJ* 1993;306:1589-93.

### Local training also has major impact

EDITOR,—T M Cook and J Handel raise several important points concerning the management of cardiac arrest in hospital.<sup>1</sup> We agree that it is vital to audit the cardiac arrest system and its performance in hospitals, and we are starting our own audit shortly. We found it interesting to note that Cook and Handel's preliminary results showed that the European Resuscitation Council's guidelines on resuscitation were not available in over a third of the arrests attended. In this hospital there is a copy of the advanced cardiac life support guidelines in each emergency drug box.<sup>2</sup> Thus when the box is opened at an arrest the sheet is removed and given to the leader of the arrest team, who then has the guidelines immediately to hand. We believe that this would be a simple solution to the problem and should be universally adopted. The last few editions of the *British National Formulary* also contain a miniature version of the European

Resuscitation Council's guidelines<sup>3</sup>; this source is readily available on most wards.

Posters are also displayed in all ward areas of this hospital. Training for both medical and nursing staff is enhanced by the work of three part time resuscitation training officers (nursing staff in the coronary care and high dependency areas). Obviously, advanced life support courses approved by the United Kingdom Resuscitation Council remain the gold standard in training terms for leaders and members of cardiac arrest teams, but local training can have a major impact on performance and should be encouraged.

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1 Cook TM, Handel J. Management of ventricular fibrillation by cardiac arrest teams. *BMJ* 1995;310:466. (18 February.)

2 Advanced Life Support Working Party of the European Resuscitation Council. Guidelines for advanced life support. *Resuscitation* 1992;24:111-121.

3 BMA and Royal Pharmaceutical Society of Great Britain. *British national formulary* No 28. London: BMA, RPSGP, 1994.

### Problem solving treatment for major depression in primary care

#### Problem solving treatment is time consuming

EDITOR,—Controlled evaluations of psychological treatments in general practice are greatly needed. Two important issues, however, are not discussed by L M Mynors-Wallis and colleagues in their evaluation of problem solving treatment in primary care.<sup>1</sup>

Firstly, their problem solving intervention is time consuming. Each patient in the problem solving group received an average of 214 minutes with either the general practitioner or a psychiatrist. This is relatively brief for mental health professionals, but such a commitment of time by general practitioners is impractical. Much more attenuated treatments will need to be developed before they will be taken up by general practitioners.

Secondly, the authors comment in their discussion that potentially suitable patients may not have been referred to the study because they were unwilling to take part in a trial with a randomised allocation to treatment. This is an extremely important point, about which no other detail is given. It is impossible from the authors' results to estimate how representative their patients were of all those with major depression attending the practices. We realise that it is difficult to make accurate estimates of patients not referred by general practitioners, but some estimation is crucial. One way around this difficulty is to use a patient preference controlled trial, in which only those patients who have no strong preference for one of the treatment arms are randomised; the remainder are given the treatment of their choice.<sup>2</sup> Thus all patients eligible to enter are retained in the trial, and the results in those randomised and those not randomised can be analysed separately.

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1 Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995;310:441-5. (18 February.)

2 Brewin CR, Bradley C. Patient preferences and randomised clinical trials. *BMJ* 1989;299:313-5.