trouble should recur, but two or three times is all that has ever been required. I hope this note may be of use to those faced with this problem. Its rationale is out of my province, but its efficacy is not in doubt.—I am, etc.,

Wolverhampton, Staffs. HENRY B. YOUNG.

Errors in Operating Theatres

SIR,—Recently an article appeared in a newspaper for a proposed meeting of senior theatre staff to discuss errors in the theatres, resulting in the wrong patients being operated on, or the wrong operation performed. That such a meeting need be called is deplorable; more so that it should be published, thus suggesting to the public that a negligent attitude might exist in our surgical teams.

We are all liable to errors, but when they occur they are our own, and must not be blamed on to willing assistants. I have committed the offence in theatre once, in performing a hernia operation on the wrong side—this was because of a clerical error in placing the hernia on the wrong side in the out-patient notes, ward notes, and operating list. Nevertheless the final blame becomes the surgeon's in not checking pre-operatively, and cannot be attributed to anyone else.

The blame rests fully on big names and small names in the profession who fail in what should be a standard routine in all hospitals—namely, to check patients themselves, pre-operatively in the ward, instead of delegating responsibility to a minor member of the profession or placing the onus on a member of the nursing profession.

Surgeons may eliminate these operating-theatre errors by the following logical principles: (1) Examination of operation area pre-operatively by the operator himself in the ward; (2) courtesy greeting to patient in anaesthetic room; (3) simple procedure for listing patients going to the theatre, and the change over of cases during a list.

Closer attention by senior members to smaller details would make the above principles easy to follow: Everyone follows this procedure for private patients, so it is a disgrace to our name as a profession that few follow it for public hospital patients. Let us be more practical and shoulder responsibility that is justly ours.—I am, etc.,

London W.2. W. J. ORAM.

Detection of Glaucoma

SIR,—The correspondence relating to the detection of glaucoma has become so wide that it is necessary to put the whole of the ophthalmic services in their proper perspective.

There are several facets: the eye hospitals and the eye departments in general hospitals, the consultant ophthalmologist, the ophthalmic medical practitioner, the ophthalmic optician, and the dispensing optician. The ophthalmic optician's main purpose being the correction of refractive errors and the referral of suspected pathological conditions to the patient's general practitioner, it is hardly possible to call a person so qualified a layman.

His course of training takes four years. He is then subject to rules and regulations of the General Optical Council, the opposite number of the General Medical Council. A medical student spends perhaps one or two half-days per week for three months in an eye department. How many medical students have to answer a question on eyes in a written paper, and how many are given an eye case during the clinical examination? One ought to remember there is such a thing as systemic ophthalmology. Most opticians know far more than general practitioners do about eye conditions. This, of course, puts the ophthalmic medical practitioner in a different class.

Having said all this it does not mean that everything is satisfactory. Far from it. The consultants should allow ophthalmic optics students into their departments and so make available to them more clinical material. They should also open the doors for the pre-registration year of experience.

As regards the ophthalmic optician he has much to do to establish himself. He should begin to realize he is no longer a shopkeeper. Furthermore, the pernicious practice of consultants or ophthalmic medical practitioners working on a sessional or fee basis for either ophthalmic or dispensing opticians ought to be abolished. It would be of advantage if the principle applicable to the general practitioner—one principal, one assistant—were adopted. This would go a long way towards the status of the ophthalmic optician being raised.

The ophthalmic services have come to stay. The sooner everybody realizes this the better. It is no use entering the field of recrimination; a *modus vivendi* has to be established.

To revert to the original point, ophthalmic opticians do an ophthalmoscopy on all their patients. Many opticians are also now doing field checks on patients over the age of 40. This by itself is not enough. Glaucoma clinics must be established under the supervision of consultants in their hospitals. Has the Ministry of Health realized the urgency?

The question of cost should be of secondary consideration.—I am, etc.,

London N.W.2. MAX SORSBY.

Airways

SIR,—It is customary in most anaesthetic rooms to have a supply of Guedel airways; these usually have a metal sleeve with a flange inserted into the upper end of the airway (see illustration, *right*). However, it does not appear to be realized that there is also a type of airway with a hidden metal sleeve and without a visible metal flange at the upper end of the airway (*centre*). A member of the theatre personnel, not realizing there was a hidden metal sleeve, decided to insert a metal sleeve with a flange; this forced the partly hidden metal sleeve further down the airway, leaving a small gap in the airway between both metal flanges (*left*). On removal of the airway at the end of operation through clenched teeth,