CORRESPONDENCE

Correspondents are asked to be brief

General Practitioners and Medical Television

SIR,—The findings from Newcastle (13 February, p. 392) under the heading "General Practitioners and Medical Television" should not be allowed to pass without comment.

The figures reported are capable of a completely different interpretation. Given that the 10% sample of the 1,000 general practitioners in the Newcastle area is acceptable, 89% is a very high figure for those who had seen at least one programme. To question the value of programmes which are regularly watched by over 20% of the target audience is to show ignorance of the regular attendance of practitioners at other forms of postgraduate education and to underestimate the effect on doctors watching in their own sitting-rooms.

There is undoubtedly some confusion in the article and therefore presumably in the minds of the general practitioners interviewed between programmes transmitted by Tyne Tees Television in the Newcastle area and those in the "Medicine Today" series broadcast nationally by the B.B.C. No mention is made of the Tuesday lunchtime transmission on B.B.C.2. This has been the conventional transmission time for over five years. The claim that only four out of a hundred doctors knew in advance of the B.B.C. programmes is only to confirm the difficulty in publicising them. In fact, during the last two years, every general practitioner in the Health Service has received, by post, information about dates, times, and programme content for every "Medicine Today" transmission. Each of the medical journals, as well as most of the weekly medical newspapers and magazines, have also carried information on transmission times.

The Association for the Study of Medical Education has been monitoring the B.B.C. transmissions. This has been done through groups of general practitioners in postgraduate medical centres and hospitals up and down the country, and by individual sampling of doctors viewing the programmes at home. Their reactions, the total numbers viewing and their interest in the programme "Medicine Today" have been recorded for nearly four years. There has been a steady increase, both in the number of doctors viewing and in the interest taken. Deductions from our own studies and from those of Arleen Smith[1] suggest that between 20% and 30% of general practitioners watch any given programme. Our best responses have indicated that as many as eight or nine thousand watch a particular programme. There are an increasing number of discussion groups approved by postgraduate deans for recognition under Section 63. Thirty of these report regularly to us, and many certainly exist about whom we have not yet heard. It is also certain that a large number of hospital doctors watch the programme, as indeed do nursing staff, local authority staff, and medical students. This surely does not show a lack of interest. What other postgraduate medical effort reaches so large and wide a professional audience?

In their discussion, Dr. J. H. Walker and his co-authors made suggestions of topics for programmes—smoking, obesity, exercise, contraception, child development, and accidents. These have in fact all been included in the B.B.C. productions. As to current developments in clinical medicine, the subject of one of the leading articles in the same issue of the *B.M.J.* ("Drugs Altering Anticoagulants" p. 360) was screened by "Medicine Today" nine months ago.—We are, etc.,

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Chairman

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Honorary Secretary
Television Section of the Association for the Study of Medical Education
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1 *Postgraduate Medical Television Programmes*, Arleen Smith, Glasgow Postgraduate Medical Board, 1968.

Emergency Tracheostomy

SIR,—The case of the child who died for want of a difficult emergency tracheostomy prompts me to bring to your notice a procedure known as "mini-tracheostomy," in which an intravenous No. 1 needle or Braunula is inserted percutaneously into the lumen of the trachea through the cricothyroid membrane. This procedure was first described by Dr. O. H. Belam and myself in 1967[1] and more recently in a handbook for house officers.[2] The range of positive pressures which occurred during obstructed expiration was from 50-150 mm Hg and the range of negative pressures during obstructed inspiration was from 50-100 mm Hg.

The volume of air passing through three types of intravenous needles at three different pressures is shown in the Table.

Pressure (mm Hg)	Volume of Air (ml)		
	No. 1 Needle	Size 0·5 Braunula Intravenous Cannula	Size 1 Braunula Intravenous Cannula
50 ..	500	1500	2700
100 ..	700	1300	3800
150 ..	950	2700	4600

In a dire emergency mini-tracheostomy may be life saving and can be performed by inexperienced doctors.—I am, etc.,

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1 Davies, I. J. T., and Belam, O. H., *Practitioner*, 1967, **199**, 76.
2 Hopton, D. S., and Davies, I. J. T. *Practical Hints for Housemen*. London, Lloyd-Luke (Medical Books), 1970.

SIR,—Emergency tracheostomy is becoming a rarity now that most hospitals have a resident anaesthetist and a cardiac resuscitation team. Surgeons usually perform a relatively planned operation where indicated.

In view of the tragedy widely reported recently may I suggest the following:

(1) Every casualty officer (all hospital junior doctors?) should pay some visits to the operating theatre and learn to use the laryngoscope. Even if they do not become experts in intubating, they should be familiar with the anatomy, and be able to remove foreign bodies lodged above the vocal cords.

(2) The Abelson cricothyrotomy set should be standard resuscitation equipment in casualty departments. In short, it consists of a large bore needle with a stylet, which is inserted through the cricothyroid membrane, the stylet removed, and airway established through which oxygen may be given via a catheter.

(3) An Angiocath with an improvised guard to mark the required length may be used similarly in an emergency to establish an airway. This is much less traumatizing than a stab tracheostomy.—I am, etc.,

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