Robinson *et al* found no benefit between those who were treated with steroids and those who were not.¹⁰ The results of further studies in patients suffering from combined burns and smoke inhalation injury suggest that giving steroids leads to increased mortality and morbidity, mainly because infection occurs more often.^{11,12} Early treatment of smoke inhalation focuses on keeping the upper airways open, and there is evidence that prophylactic upper airways intubation and continuous positive airways pressure ventilation should be carried out in anyone who gives a history of smoke exposure in an enclosed space or who on examination shows facial burns or singed nasal vibrissae or produces carbonaceous sputum.¹³ Fiberoptic bronchoscopy has been recommended as an aid to making an early diagnosis,¹⁴ but this was not performed on our patients.

The three month follow up of the survivors suggested that long term physical problems associated with exposure to these fumes are rare. The two asthmatics continued to show evidence of increased bronchial hyperreactivity and required more treatment to control symptoms than previously. A 14 year old girl who was ventilated for only 24 hours developed subglottic stenosis requiring surgical intervention but subsequently recovered. The lung function of the remaining patients was normal with no evidence of appreciable bronchial hyperreactivity. The results of follow up showed a high prevalence of psychological problems, and although we examined only those who were admitted to hospital, this may be a problem for all the survivors.¹⁵

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Personal Paper

After safe sex, safe surgery?

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"Look out for the point of the cutting diathermy!" said my boss as he handed it to sister. She drove it into the back of my hand with a nonchalant grace that would have brought tears to Eric Bristow's eyes. It would not have been so bad had it not been a patient with the acquired immune deficiency syndrome (AIDS) whose lung we were biopsying. So as we peeled off our double gloves and removed our helmets and overhoods, aprons, gowns, and overboots I ruefully rubbed my wound, wondering why we dressed up in this ridiculous garb and why on earth the orderlies were bothering to wash the walls, let alone under the sinks. We were not going to catch the human immunodeficiency virus (HIV) under the sink unless we... well it's an old joke.

The current barrage of publicity describing just exactly how to avoid catching or transmitting the virus gets the message exactly right. "Your sexual partner could be that very special person—the one that gives you AIDS." For sexual partner, read patient, or surgeon for that matter, because though probably not as risky as

intravenous drug abuse, surgery is certainly as risky as life on the sexual M25, if not necessarily in its fastest lane. The advice on safe sex does not mention wearing plastic aprons and overboots, or washing down the walls afterwards, yet still gives practical protection. It is high time that we had similar practical guidelines for the protection of both surgeons and patients.

But don't we already? No, categorically, we do not. The charade of dressing up before and scrubbing down afterwards when the patient is HIV or hepatitis B surface antigen (HBsAg) positive does not constitute safe surgery. Needled into action, I have produced some more practical guidelines for debate.

Hazards

Patients, operating theatre staff, and the operations are all potential hazards. To deal first with the patients. Should they all be screened for HIV before operation? Well why not? Hang the expense. I'd like to know. Some would argue that there is no need to screen everyone, just the high risk cases. The trouble is, you just can't tell who they are. Maynard noted that selective screening of over 6000 patients would have picked up only 10 of the 59 patients who were found to be positive for HBsAg.¹ Callender *et al* showed

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that only 15 of 51 cases of hepatitis B virus infection in medical and health care personnel had a history of direct occupational exposure, and only three could recall an inoculation injury.² It seems that selective screening leads one into a false sense of security. So there are two options: screen everyone preoperatively, or, more realistically, treat everyone as an HIV and HBsAg risk because, even in the nursing homes of Brighton and Hove, you just never know. This is the attitude recommended by the Minister of Health for sexual purposes, so it should do for the average operation.

Secondly, the surgeons: for the average patient contact with us is as close as they will get to the fast lane. We know that clinical viral hepatitis is four times commoner among American hospital employees than in the general population³ and 10 times higher among British surgeons than among the general population of London.^{4,5} So being in a high risk profession I think we should all have mandatory annual blood tests for HIV state and to confirm the active immunisation against hepatitis B, which we should all by now have received,⁶ is effective. Unlike an even older profession, both doctors and nurses generally have an employing authority whose responsibility it should be to see that not only do operating theatre staff receive adequate protection from an industrial disease but also that patients are not being operated on by the surgical equivalent of Typhoid Mary. Would anyone refuse the blood tests? I don't think so, because the patients and the employing authorities must treat us as infectious risks until then, for the same arguments that I used about patients above. But what happens if one of us is positive? Compensation and the good life would be my recommendations. To find that one had been operating on people for years, spreading the disease, would be grim.

Finally, and most importantly, what about safe surgery? There

are only two main ways in which the surgeon's and patient's body fluids get a chance to mingle in professional circumstances: needlestick injury and getting blood in the eye. Needlestick injury can happen to anyone, inadvertently pricking the sleeping beauty assistant, or more often oneself. Blood in the eye is particularly common in some operations: notably cardiac and orthopaedic, if a recent straw poll conducted at the Middlesex is accurate.

Needlestick injury could be prevented by making the handling of any sharp instruments a technical error, if not an offence, for the trainee surgeon. "No touch technique" which achieved popularity before antibiotics became available should be resurrected for handling needles, instead of tissues. Not a terrible burden, more a sensible practice to be adopted. Blood in the eye could be avoided cheaply and simply by wearing protective glasses while operating.

Safe surgery does not entail wearing plastic overshoes and washing the walls after the AIDS patient has left the operating theatre. Quite simply, every patient must be treated the same, by safe surgeons, with safe techniques, and protected conjunctivae.

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What is a Good Consultant?

When you have a terminal illness

One of my qualifications for answering the question "What is a good consultant?" is that I have the acquired immune deficiency syndrome (AIDS). This has brought me into contact with a lot of doctors. AIDS has pushed genitourinary consultants into the limelight and the forefront of medicine. They used to work away and not expect or receive much credit. Now they tell a patient weekly, if not daily, that he or she has a terminal illness. In general they have risen to the occasion, calmed the public, and been sympathetic to the plight of the person with AIDS. They know that they have no cure, and so they concentrate on treating things that they can treat and passing on facts to allay the public's well founded fears. Their honesty and openness have been striking. They have confronted a terrible challenge, publicly defended and fought for their patients' rights, and remained caring and hopeful in the face of all publicity, some of which seems to come from the drains beneath them. Indeed, some have even risen to the precarious height of being media stars.

My mother, who has angina and arthritis, insists that her consultant must be good because he has "such wonderful hands." He certainly has patience, whereas my father's consultant never spoke to him, my mother, or to me. Once, when cornered, he attempted to speak at me but quickly retired behind an excellent registrar.

A good consultant has to be a good listener. He needs to know more than a radiograph tells him, and often the patient feels a symptom that is of far more use in a diagnosis than any medical test. The consultant who stands at the foot of the bed mumbling about

you to his registrar is negating his basic worth with his pomposity. All the rules of common good manners must be followed when dealing with a patient, and the consultant must remember that the patient has not spent eight years studying medicine. Everyone has the right to be told exactly what is wrong with them, but it has to be communicated clearly so as to leave no doubt in the patient's mind. This is important with anything from piles to pneumonia caused by *Pneumocystis carinii*. I was once seen by a consultant who after shaking my hand proceeded to scrub up. He had just told me that I had AIDS, and I found his reaction cruel and unfeeling.

We assume that when we see a consultant we are at long last in the hands of an expert, but he can never presume that we have to do what he recommends us to do. A good consultant never forgets that the treatment is the patient's choice. He must guide, advise, and then, with the patient's permission, treat. Too many consultants forget this basic human right, and most will never consider any kind of alternative treatment. This, I think, shows a great narrowness.

As in all human relationships a good consultant has an indefinable quality for you the individual. It is all down to personalities, and this is when the well modulated, authoritative voice and the well manicured hands come into their own. Now is the time for giving your trust to this person whom you suspect would rather be in a luxurious office in Harley Street than walking these National Health Service wards. Then, after this initial meeting, comes the treatment—and the final question. Can he make me well? If he can and does he is a good consultant. If he cannot he isn't. In many ways it is as simple as that.