for a place for his son in a medical school, his son having passed "A" levels (not at his first attempt), with one B and two Ds. I have heard of several medical colleagues whose sons or daughters have failed to get into a medical school because they did not get high enough grades at "A" level.

What are we training doctors for? Are they all destined to become high-grade specialists or Fellows of the Royal Society? Doctors in general practice do not require an esoteric high-brow intellect, yet nearly half the graduates are destined for general practice. They require patience, humanity, common sense, and an ability for hard work in the field.

Hippocrates favoured the training of the sons of doctors in the profession and it used to be the practice in Britain. I suggest that it is high time that we returned to it.—I am, etc.,

N. GEOFFREY NICHOLSON

Ashford, Middlesex

SIR,—I most strongly disagree with the point of view expressed by Mr. Oliver Dearlove (10 November, p. 360). I do not consider that a medical home background is of any great benefit to one's training—indeed it all too often leads to the case of a son being expected to follow in his father's footsteps, even when he is not strongly motivated. This can lead to unfortunate failures and a wastage of valuable medical school places.

Furthermore, although "A" level results may not be the best guide, they are a good standard. I fail to see why, if somebody cannot get a place by normal methods—that is, the Universities Central Council on Admissions (where interviews usually are taken into account)—his father's position and willingness to finance advertising should entitle him to any advantages.—I am, etc.,

CHRIS NORTH

Medical Faculty,
University of Sheffield

Ambulance Personnel

SIR,—I read with satisfaction the letter from Dr. W. S. Parker (10 November, p. 359) concerning the Brighton ambulance men who participated in the mobile coronary care scheme. The attitude they and their union adopted typifies the professionalism we need to encourage in this important body of men; it does much to establish them as paramedical technicians—much more than the current regrettable industrial action. I have a deep interest in the status of ambulance men, being the medical representative of the Institute of Certified Ambulance Personnel on the Board of Registration of Medical Auxiliaries.

I would like to point out that there is provision for ambulance men who have obtained the Diploma of the Institute of Certified Ambulance Personnel to obtain admission to the National Register of Medical Auxiliary Services of the Board of Registration of Medical Auxiliaries at B.M.A. House. It is true that this is a small beginning, but all paramedical professions had to start somewhere and I believe that such a recognition of training and qualification will be greatly to the advantage of ambu-

lance men from a professional point of view. Physiotherapists, occupational therapists, chiropractors, and others who have comparably intimate contact with patients originally registered in this way but are now recognized on the Statutory Register of Professions Supplementary to Medicine. Such graduation is the essential function of the Board.

Doctors should encourage in ambulance men a professional attitude at all times; this begins by recognizing their importance and enhancing their pride in professional status.

—I am, etc.,

REGINALD ELSON

Woodsetts,
Near Workop,
Notts.

Anaesthetic Safety Devices

SIR,—Dr. C. Burke (3 November, p. 229), no doubt unintentionally, gives the impression that common sense regarding the oxygen supply to anaesthetized patients might be the prerogative of anaesthetists in Canada and the United States. I can reassure him that fuel cell and oxygen electrode meters are readily available in Britain, albeit of American manufacture, with their advantages of displaying the inspired oxygen concentration received by the patient and giving an audible and visible warning if the concentration is above or below preset limits. In this way a failure of oxygen or nitrous oxide supply can be made known.

A fail-safe device as described by Mr. R. J. Davies (3 November, p. 229) is clearly an additional desirable feature, while an alarm to detect accidental disconnection of the patient from the anaesthetic circuit, particularly during controlled ventilation, would seem to be essential.

If these aids to the safety of anaesthesia are not generally in use it might suggest a surprising complacency by specialists in this field.—I am, etc.,

J. M. MANNERS

Southampton

Aerosols and Asthma Deaths

SIR,—It is usually assumed that the decrease in the number of deaths from asthma which followed the official warning about pressurized aerosols containing sympathomimetic drugs¹ was due to the stricter controls on the supply of these aerosols. This hypothesis has, however, been questioned by several authorities.²⁻⁵ Another possible explanation for the decrease in mortality after the warning was issued could have been a change in the attitude of general practitioners to the treatment of asthma, and this may have been the reason why more patients with asthma were admitted to hospital at that time,⁶ and why there was an increase in the number of prescriptions for corticosteroid drugs,⁷ which could both have contributed to the reduction in mortality. It is apparent from the recent correspondence in these columns that there is no convincing evidence to incriminate aerosol propellants as a major cause of death in asthmatic patients.⁸⁻¹¹

Though the reasons for the reduction in asthma mortality are not clear and may not be directly related to the decreased use of pressurized aerosols, it is obvious that we must constantly endeavour to ensure that our

patients do not overuse pressurized aerosols of any type. We must not, however, deny them this most efficient method of bronchodilator drug administration. Ever since the possible association of increased deaths from asthma and aerosols was suggested many doctors have been reluctant to prescribe pressurized aerosols because of the fear that they may be used indiscriminately. As a result, oral sympathomimetic amines are frequently prescribed, sometimes in combination and in massive doses, in an attempt to control asthmatic symptoms which could be more rapidly and effectively relieved by the same drugs in much smaller doses if given by aerosol. Pressurized aerosols are often reserved for patients with severe asthma because of their potential dangers, and patients with less severe symptoms are often treated with oral therapy. It is, however, wrong to withhold inhalers from patients with mild asthma as this is denying them the most efficient method of relieving their symptoms, and with such patients there is little or no danger of inhaler overuse as their symptoms are not likely to be distressing enough to encourage it.

The risks of toxic effects from oral sympathomimetic drug therapy are often overlooked. Salbutamol, the most widely used bronchodilator drug, is manufactured in two tablet strengths, 2 mg and 4 mg, and these are commonly prescribed in preference to the pressurized aerosol, which delivers 100 µg of salbutamol per dose. Surely it is irrational to prescribe any drug by mouth in a dose which is 20 or 40 times larger than the effective dose by inhalation. Even more difficult to justify is the concurrent use of sympathomimetic amines like salbutamol by mouth and by inhalation.

Dose for dose, inhaled salbutamol is cheaper, more rapid in action, more effective, and has less undesirable side effects than oral preparations. The medical profession has perhaps been alarmed by the continued debates about the potential dangers of aerosols in asthma and has tended to favour the use of oral sympathomimetic drugs in preference to aerosols. There should be, however, only one indication for the use of oral sympathomimetic amines in asthma—when, for any reason, a patient is unable to use a pressurized aerosol.—I am, etc.,

GRAHAM K. CROMPTON

Respiratory Diseases Unit,
Northern General Hospital,
Edinburgh

- 1 Inman, W. H. W., and Adelstein, A. M., *Lancet*, 1969, 2, 279.
- 2 Clark, D. G., and Tinston, D. J., *Annals of Allergy*, 1972, 30, 536.
- 3 Silverglade, A., *Journal of the American Medical Association*, 1972, 222, 827.
- 4 Gandevia, B., *Medical Journal of Australia*, 1968, 1, 884.
- 5 Harris, M. C., *Annals of Allergy*, 1971, 29, 250.
- 6 Dollery, C. T., *Annals of Allergy*, 1973, 31, 38.
- 7 Inman, W. H. W. (1973), *Proceedings of Symposium on evaluation of bronchodilator drugs*. (To be published.)
- 8 Archer, V. E., *British Medical Journal*, 1973, 3, 696.
- 9 Herweimer, H., *British Medical Journal*, 1973, 4, 171.
- 10 Spilker, B., *British Medical Journal*, 1973, 4, 171.
- 11 Silverglade, A., *British Medical Journal*, 1973, 4, 235.

Relapsing Polychondritis and Pulseless Disease

SIR,—With reference to your leading article on "Relapsing Polychondritis" (16 June, p.