patients in such evaluations were overlooked. Evaluation should not be considered as anything but constructive for those evaluated. It should provide feedback to improve patient care. Those involved in an evaluation with simulated patients should agree to the valuation. In addition, they must be instrumental in the design of the evaluation, especially the observations to be made by the simulator. Of course, the simulated patient does not have to be personally involved in the evaluation.

Since the simulated patient offers a standardized, unvarying medical problem, subsequent analysis of health needs produced by those who cared for the simulated patient can be carried out. However, if the simulated patient is to be involved in observation it is imperative that he be trained for consistency and objectivity. The anonymity of the simulation assures that no special treatment is given to this patient either consciously or subconsciously, as he is not recognized as the patient in the system. The statement that simulated patients would be a drain on health care costs seems exaggerated. The cost of the odd non-patient should be well overbalanced by the value of the exercise in improved efficiency and effectiveness in real patient care. Quality control, to be effective, has a calculated cost. Though your article mentions other methods for evaluating health care, none is as direct as measuring the effect of health care delivery on patients by putting a standardized patient into the system. Many factors important to patient care cannot be detected by visits or interviews of patients who are dependent on the health care system in which they are involved.

The great value of feedback provided by simulated patients to students, physicians, and nurses over the 12 years that I have utilized the technique has been amply demonstrated. In addition, the persons evaluated almost always appreciate the value of the information and insist on more evaluations of themselves by this technique.

— I am, etc.,
H. S. BARRIOS
McMaster University, Hamilton, Ontario

Drug Combinations for Anaesthesia

SIR,—Dr. M. W. P. Hudson (9 November, p. 345) advocates the use of intravenous methohexitone followed by diazepam (up to 10 mg) for induction of anaesthesia prior to endotracheal intubation. Since reading his letter I have tried this method in 25 inpatients (20 male, five female) scheduled for oral surgery. After intravenous injection of 80 mg methohexitone and 10 mg diazepam the patients were ventilated vigorously for one minute with nitrous oxide/oxygen and halothane 2% or, for very robust patients, 3%. Conditions for intubation were considered to be difficult in 14 patients and impossible in one (requiring the use of suxamethonium). As part of a separate study arterial blood samples were taken for blood gas analysis as soon as stable anaesthesia was obtained. Surprisingly, arterial oxygen tension (PaO₂) less than 10.6 kPa (80 mm Hg) were found in five out of 17 patients, though clinically ventilation seemed to be adequate and the patients were breathing 35-40% oxygen.

To decide whether this effect was due to the drug combination 10 fit patients aged 30-42 years (nine male, one female) due for minor surgery had anaesthesia induced with 125 mg methohexitone and 10 mg diazepam. The jaw was supported once the patient was asleep to avoid respiratory obstruction. Arterial blood samples were taken 2-3 min after induction while the patients were still breathing air and recovering from the transient apnoea which is a feature of this form of induction. Several were light enough to react to the needle prick. Arterial blood was drawn in the same way between 12 and 65 kPa (31 and 65 mm Hg). The mean value (± S.D.) was 6.45 ± 1.21 kPa (48.5 ± 9.1 mm Hg). Slight cyanosis was detected in only one of these patients. In a 65-year-old woman having a similar induction PaO₂ was 4.79 kPa (36 mm Hg). These figures suggest that transient marked hypoxia is the rule with this drug combination used in patients breathing ambient air and presumably not relating to hypoxia of methohexitone or any degree of respiratory obstruction (which may be so difficult to detect) will prolong the hypoxic period.

We can expect to read more reports of deaths during dentistry (9 November 1974, p. 352; 8 February 1975, p. 341) as long as this drug combination is used without oxygen enrichment, the case for which was so forcibly advocated in your recent leading article (8 February, p. 293). Reading the reports of the inquests on the unfortunate victims, one cannot but feel that being by the time the patient has collapsed become impossible. As in the case of the high PaO₂ hypoxia has probably been present for a considerable period of time and recovery is unlikely. — I am, etc.,
J. P. ALEXANDER
Belmont City Hospital, Belfast

Skin Reactions to Beta-blockers

SIR,—Since our original report (9 November, p. 321) we have extended our observations to a total of 48 patients with cutaneous reactions to practolol. Thirty-two of these patients have subsequently been treated with alternative beta-blocking agents (26 with oxprenolol, four with propranolol, and two with both). Fourteen of these patients had previously been challenged orally with practolol and all had developed a rash as previously described—usually within 2-3 days. No patient developed skin lesions during periods of up to 30 months' treatment with alternative beta-blocking agents. In eight patients the practolol-induced rash was still present when alternative treatment was started and in all of them it cleared completely within a few weeks. We have also observed conversion from positive to negative serology for antinuclear antibody in three patients subsequently treated with oxprenolol.

Despite the report by Dr. B. St. C. Cumberbatch (30 November, p. 528) of a psoriasis skin reaction associated with oxprenolol treatment our observations demonstrate a lack of cross-reactivity between practolol and other beta-blocking agents with respect to these side effects. On the present evidence the advice of the manufacturer1 to treat practolol-sensitive patients with alternative beta-blocking agents appears well founded. — We are, etc.,
R. H. FELIX
F. A. IVE
M. G. C. DAHL
University Department of Dermatology, Royal Victoria Infirmary, Newcastle upon Tyne


3 Oxprenolol is now a commonly used drug and this complication must be rare, though it is conceivable that such cases may be missed in view of the long interval between the administration of the drug and the onset of symptoms. — We are, etc.,
Paul L. Padfield
D. G. BEEVERS
M.R.C. Blood Pressure Unit, Glasgow

Rebecca Cochran
A. McQueen
University Department of Dermatology, Western Infirmary, Glasgow

1 Ridgley, C. M., British Medical Journal, 1974, 4, 292.
3 Department of Health and Social Security, Committee on Safety of Medicines. Adverse Reactions Series No. 11. London, D.S.I.R. 5.5.74.
4 Cumberbatch, B. St. C., British Medical Journal, 1974, 4, 538.