halothane jaundice." As we stated in our introduction, we set out to determine on the basis of the hypothesis, derived from clinical reports, that multiple halothane anaesthetics are a factor in the development of jaundice, whether a time interval between the anaesthetics could be defined in which this danger particularly exists. In this, we feel we have succeeded in at least reducing the uncertainty.

Our survey of the general surgical population exposed the incidence of and the time intervals between multiple anaesthetics, which had been almost unknown. We then compared this information with that which we obtained from the Committee on Safety of Drugs of patients who developed jaundice after halothane and had been reported by anaesthetists. Indeed, when in halothane tions of the Hospital for this, they might have come with their con- gested lists much quicker if they touched a Spencer Wells with the diathermy needle than if they tied the vessel off. Other factors that occur to me are: The techniques of regional blockade, especially caudal, was used in many cases but one must admit they were time consuming, and those hospitals that justifi- ably claimed excellent results from spinal anaesthesia were quite rightly frightened off by the awful, if remote, risk of arachnoïditis.

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Ketamine Anaesthesia

SIR,-We were very interested to read the comments by Professor J. W. Dundee and Dr. J. Moore (3 July, p. 46). Our investigation was performed on patients anaesthetized with ketamine using dosages recommended by the manufacturers and preceded by their suggested anti- arachnoid premedication. The total dosage of ketamine was 0.5 mg/kg/min., which is similar to that used by other workers.1 We performed our tests at the termination of surgery whereas Professor Dundee and Dr. Moore tested their patients as soon as anaesthesia had been stabilized.

The timing and the nature of the laryn- geal challenge are possibly two factors which may influence the likelihood of aspiration. This, together with the effect of varying the premedication, will require further investiga-

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1 Corssen, G., and Domino, E. F., Anaesthesia and Analgesia ... Current Researches, 1966, 45, 29.


Accident and Emergency Services

SIR,-Publicity has been given recently in the national press and the B.M.J. to changes in the staffing of accident and emergency (casualty) departments. It is proposed that a career structure should be created and pilot training schemes are to be instituted. In the discussion which led to these decisions the Orthopaedic Group of the British Medical Association and the British Ortho- paedic Association, whose consultant mem-

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Halogen Anaesthetics

SIR,-I am too old and have been retired too long to be able to make any useful suggestions about the treatment or prevention of halothane jaundice, but I could, if permitted, make some observations on its possible aetiology.

Over a half century ago we had a similar problem in delayed chloroform poisoning, a similar deadly liver lesion, and this, with other factors such as the frights we got from the dreadful falls in blood pressure when giving chloroform, made many of us feel that the halogen anaesthetics were a bad lot. Indeed, when this latest one with fluorine came in I remember remarking that I should be surprised if sooner or later trouble with it were not experienced. We moved on to the safest of all general anaesthetics: ether and the hydrocarbons, cyclopropane, etc.

What pushed us off? I am afraid we must blame our surgical colleagues for this. They found that they could cope with their con-

At the Belfast meeting of the British Orthopaedic Association in April this survey was presented, together with a report from the accident services subcommittee of the Association, and the following recommenda-

1 There should be one experienced doctor on duty in the accident and emergency departments during the whole 24 hours each day of the week. Four such doctors will be required in each department to work a rota allowing time for sickness, holidays, study leave, etc. These doctors would be experienced in handling all forms of casualty work, and it would be essential to establish for them a permanent career grade which should be financially competitive with ordinary general practice. Their experience should be gained in accident and emergency departments in the course of a year or two, and special courses would be arranged by regional hospital boards to assist their training. Provided that at some time a doctor was on duty in the department then the other medical staff in the department could be senior house officers or even pre- registration house officers. These should be regarded as training grades.

2 There should be a consultant in charge of the whole accident service, including inpatient beds and outpatient clinics, a function already largely taken on by orthopaedic surgeons. The consultant should be responsible for the organization and supervision of the work of the department, and he should be enabled to spend adequate time in the accident and emergency department. Time for work in the department should therefore be included in the sessions in his contract.

The pattern of manning departments will vary throughout the country, and it is important that a rigid plan is not imposed, and that some flexibility is permitted. We are, etc.,

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