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In response

Professor Ebrahim did not state that medical students 'use' the pejorative terms 'geriatric crumble' and 'GOMER' or even that 'some' (whatever that means) have the wrong attitudes. He actually wrote[1]: 'medical students still rejoice in their stereotypes of geriatric crumble and GOMER patients'. He produced no evidence to support this sweeping generalisation, nor even some thoughtful anecdote. Nor does he now. I did not consider his views unfounded *because* of my sample of student views, but because his statement both lacked evidence and failed to correspond to experience. Nor do I understand the logic of arguing that we should know such generalisations apply to North Americans because the *BMJ* is an international journal. Professor Ebrahim seeks to defend the indefensible.

His assertion that doctors exhibit prejudicial views is self referenced to his own editorial, while his view that I consider CPR to border on futility in terms of effectiveness is incomprehensible. As I wrote[2], at its best, CPR is the gift of life – not my idea of futility. The fact that it usually fails is beyond debate.

The increased documentation of DNAR orders in two of the three hospitals surveyed by Ahronheim *et al*[3] was not associated with a change in the use of CPR, nor was this found by Kamer *et al*[4]. Even the improvement in documentation was not recorded in US hospitals with policies in place[3,5]. So there is no evidence that legislation would be helpful in the UK. More significantly, I am aware of no legislature in the world that has followed New York State in the last 14 years. Moreover, no series of inappropriate failures to initiate CPR has ever been published nor do I know of any anecdotes.

Faced with an unaccompanied dying patient in the A&E department in the small hours of the morning, time does not always permit explanations of urgent decisions. This is the reality of acute medicine for many of us. A treatment that offers the prospect of more harm than good does not promote a patient's best interests and constitutes an unethical assault. I hope the sort of scenarios recently described by Soper[6] or Foxton[7] are rare. To assume that would be real complacency.

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Editor – I am concerned over the current discussion on resuscitation. Little mention is made of the role of the nursing profession at the sharp end of this debate. It is often a relatively junior nurse, maybe a locum and in the middle of the night who may come across a collapsed patient. There is a complex differential diagnosis of this clinical situation. Nurses are not trained in the art of diagnosis. Even the diagnosis of death is known to have its own pitfalls (all good housemen leave 30 minutes before going to certify a corpse!). How can it be appropriate to consider 'do not resuscitate' or even 'do not attempt resuscitation' when the diagnosis of the acute downturn in the patient's condition will not have been made.

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Biological weapons: the facts not the fiction

Editor – It is disappointing that the College's seminar on biological warfare (as reported in *Clin Med JRCPL* November/December, pp 502–4) made no mention of the most important measure to control biological weapons, namely the 1972 Biological and Toxin Weapons.Convention (BTWC), not least as it was in the news at the time of the seminar. The BTWC bans the production, testing, stockpiling or use of bioweapons, though not purely defensive research as on vaccine production. Such conventions can be breached by states parties, as in the Soviet research cited at the seminar and by Iraq before the Gulf War.

A major shortcoming of the BTWC is that it has no provision for verification. A verification protocol for the BTWC has been under negotiation for several years but was rejected by the current US administration at the November/December 2001 review conference, although it would have allowed a challenge inspection of a state outside the convention suspected of involvement in the recent anthrax outbreak. The US gave two apparently contradictory reasons for its rejection, that the protocol was not strong enough and that it would endanger the commercial confidentiality of its biotechnology industry. There is however suspicion that recent research in the US has been at least 'testing the limits' of the BTWC[1].

It is vital that efforts to establish the verification protocol and enhance the effectiveness of the BTWC should continue.

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Clinical aviation medicine: safe travel by air

Editor – I read Raymond Johnston's forum on clinical aviation medicine (*Clin Med JRCPL* September/October 2001 p385–8). The medical community certainly needs to increase its knowledge in this area. Johnston's review of physiology and specific medical conditions omits congenital aspects of the heart and the lungs, and individuals with cyanotic congenital heart disease, especially those with pulmonary hypertension and polycythaemia, in this group of patients. Minor changes in oxygen tension raise pulmonary artery pressure, this increases right to left shunt and eventually leads to systemic desaturation and metabolic acidosis. Nor should the biophysical effects of acceleration and deceleration be neglected.

A stretcher patient in prone or supine position, whose head is toward the front of the aircraft can undergo significant venous pooling and decrease in cardiac output on take off. With the exception of cerebral oedema patients, the head should be positioned toward the rear of the aircraft. This is particularly important for patients with low cardiac output and left ventricular outflow tract obstructions. Last but not least are patients with congenital cyst of the lung. Obligatory gas expansion according to Boyle's law can compromise pulmonary-cardiac status on board. Careful speculation is needed before we sign the aircraft form for our patients who give us full trust.

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Autoimmune haematological disorders

Editor – For the sake of completeness, Dr Provan's excellent review of autoimmune haematological disorders (*Clin Med JRCPL* November/December 2001, pp447–51) ought also to make mention of acquired haemophilia, with a reported incidence of 1 in 100,000, in which the aetiopathogenic mechanism is the acquisition of antibodies to factor VIII[1]. This disorder can occur in isolation, especially in elderly women, but also in association with autoimmune disease, malignancy, pregnancy, or drugs[2]. Also, von Willebrand's disease is yet another bleeding disorder in which examples can be found of immune-mediated aetiopathogenesis. Such cases are characterised by the presence of G class immunoglobins directed against the factor VIII-von Willebrand factor complex[3].

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