Correspondence : Briewerubriek

The views expressed in the Correspondence published in the Journal *are not necessarily those of the Medical Association of South Africa.*—Editor

Die menings gelug in die Briewerubriek van die Tydskrif *is nie noodwendig dié van die Mediese Vereniging van Suid-Afrika nie.*—Redakteur.

NEW RESUSCITATION CONNEXION

To the Editor: Intubation and intermittent positive pressure breathing are life-saving procedures very often applied to asphyxiated infants. During the resuscitation of the newborn it is hardly ever necessary to exceed inspiratory pressures of 20 - 30 cm H_2O.[1-4] Higher pressures are potentially dangerous and may cause a pneumothorax.

Inspiratory pressures are usually controlled by the use of a Barrie[3] or similar apparatus. Intermittent positive pressure respiration is effected by rhythmically opening and closing the open limb of a Y-connexion in the circuit. Instead of using a Y-connexion in the circuit, a hole, cut in the polythene gas line, just proximal to the endotracheal tube connexion, may be opened or closed.

The direction of gas/oxygen flow in the circuit using either the Y-connexion (Fig. 1) or the opening in the tubing (Fig. 2), is directly opposite to the expiratory flow. Thus it may hinder expiration and if gas/oxygen is administered at high-flow levels, pressure build-up may occur in the airways. This can be avoided by simply redirecting the inspiratory gas flow.

The resuscitation connexion designed by us (Fig. 3) and made in our technical workshop, alters gas/oxygen flow so that no pressure build-up is possible. The open end, when closed, redirects the gas flow to the endocardial connexion. The Venturi effect, during the expiratory phase, actually enhances expiration.

This connexion has been in use in our department for almost 2 years. General use of similarly designed resuscitation connexions will help to minimise the risk of iatrogenic complications arising during resuscitation procedures.

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1. Nelson, W. E. (1969): *Textbook of Pediatrics*, 9th ed., p. 380. Philadelphia: W. B. Saunders.
2. Hustead, R. F. and Avery, M. A. (1961): New Engl. J. Med., **265**, 939.
3. Barrie, H. (1963): Lancet, **2**, 650.
4. Hull, D. and Gardner, D. (1971): *Recent Advances in Pediatrics*, 4th ed., p. 72. London: J. & A. Churchill.

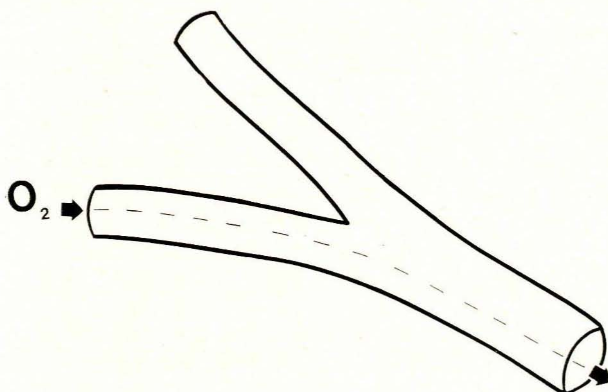


Fig. 1. Y-connexion.

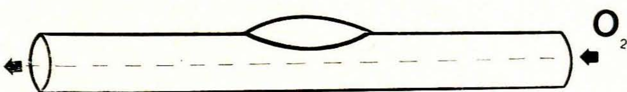
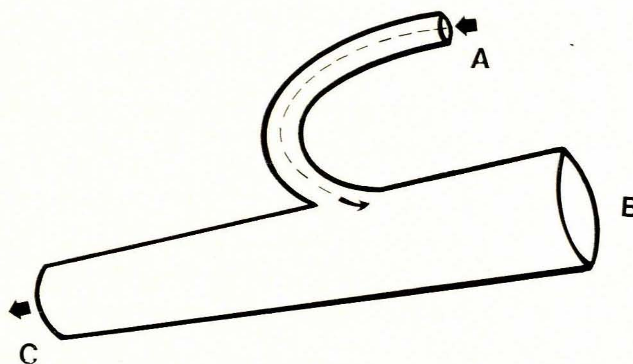


Fig. 2. Opening in tubing.



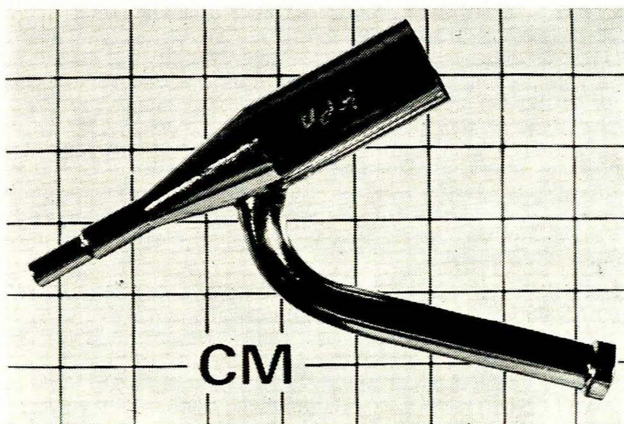


Fig. 3. Resuscitation connexion. A = air/oxygen connexion, B = open end, C = Venturi effect.

HOW TO FAIL AS A THERAPIST

To the Editor: If C. W. Smiley's article entitled 'How to fail as a therapist' was intended to be either amusing or instructive, then I failed to react appropriately.

This article includes several statements which most certainly could not be substantiated by clinical experience, statistical data or any other acceptable criterion. I do not propose analysing the details of the article from an academically critical point of view, because the general level of the article does not warrant such an approach.

What I do wish to say is that while criticism of a mode of therapy is obviously justified if backed up by sensible, factual evidence, the totally derisive tone of this article angered me and calls for objection. While criticism is always acceptable, distasteful ridicule is intolerable.

I assume—although it grieves me to do so—that C. W. Smiley is a member of our medical profession. If taken seriously, the content of his article will be misleading to those of his readers who feel unqualified to formulate their independent definitive attitudes concerning the merits of psychotherapy. Psychotherapy is such an important and essential part of psychiatric practice that this attack on psychotherapy is tantamount to a direct attack on the speciality of psychiatry.

I query the content of this article within the framework of medical ethics. I wonder how my colleagues working in mental hospitals reacted to the idea of a schizophrenic being 'securely locked up in a psychiatric penitentiary'.

Finally, it was most distressing to me to find that an article of this calibre had gained access to the pages of the *South African Medical Journal.*

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1. Smiley, C. W. (1974): S. Afr. Med. J., **48**, 37.

MEDICAL CONGRESSES

To the Editor: Dr J. G. Louw, in his letter,[1] discusses the form and purpose of the biennial congress of the Medical Association of South Africa and the extent to which this has been modified by the growth of specialism. I subscribe to the view that there is a real need for this type of congress and that it presents a unique opportunity for interdisciplinary discussion on a wide variety of topics. I do not believe that such a congress should be pitched at the needs of any single group but at the needs of the medical profession as a whole. Dr Louw has misinterpreted the attitude of the general practitioner with regard to receiving instruction from specialists. Far from resenting such instruction, we lean heavily on our specialist colleagues for information on recent advances in their disciplines. In fact, this provides the basis of our continuing educational programmes.

However, the reverse is, in fact, applicable. The general practitioner has a very real contribution to make to the body of medical knowledge. This was amply demonstrated by Drs Fry and Horders's outstanding contributions to the plenary session on medical education at the recent congress. The same is true of Drs Fry and Levensteins' paper at the symposium on coronary artery disease. The full potential of this contribution will only be realised when general practice has achieved academic recognition and departments of general practice exist in all medical schools in South Africa.

In the planning of future congresses we must naturally strive to satisfy the needs of all members of our profession. In this utopian quest we must appreciate that neither specialists nor general practitioners represent homogeneous groups. Thus we have specialists who are totally concerned with technical advances in their field. Others have broader interests and are concerned with the medico-social problems of our times, the organisation of medical care and medical education. The same is true of general practitioners, but it seems that here we have to cater for two main groups. On the one hand there are those general practitioners who view congress as an opportunity for continuing education and updating about recent advances in clinical approach and therapy. In this group are found a preponderance of older practitioners and those who are isolated from the centres of medical education. The second group is represented by those who are interested in the academic discipline of general practice, the philosophy, research and teaching thereof. Some may have a higher qualification in their discipline and many would be regarded as specialists in family medicine—an appellation not universally popular. Most of these practitioners have availed themselves of the learning opportunities provided by journals, tape recordings and lectures to keep up to date with recent advances.

Bearing in mind these different groups with their varying needs, may I suggest that future congresses offer the following programme. The plenary sessions afford the main opportunity for interdisciplinary discussion, thus providing the main feature of a congress. Much thought and discussion must be given to the selection of topics, which should include representatives from general practice—as yet the largest single group in the profession.

Unlike Dr Louw, I believe that the different disciplines should continue to hold their meetings as before. This would naturally also apply to general practice. No conditions nor reservations about the form and content of these meetings should be laid down by the congress committee. These sectional meetings provide the main congress attraction for many. Distinguished doctors have been brought to this country for the occasion and it would be a pity if we did not avail ourselves of their specialised knowledge and expertise.

For those who look to the biennial congress for clinical revision and updating, a third type of meeting should be held. Specialist groups should tbe invited to offer symposia on recent advances in their field, specifically for general practitioners. A great deal of thought and effort is involved in the preparation of these sessions. In order to ensure a good attendance, these symposia should be limited in number and should not clash in time.

Again I would like to reassure Dr Louw that the criticism voiced by general practitioners had nothing to do with the reasons given in his letter, but relate to two specific issues. Firstly, it is surely incongruous to have organised a congress 'pitched at the needs of the general practitioner', yet have no general practitioner on the congress committee. Secondly, there was a deep resentment at certain tactless and insensitive pronouncements made before and during the recent congress. I do not wish to elaborate on these issues. Suffice it to say that senior practitioners in Cape Town have privately met those responsible for these statements. In this way we have sought to explain our viewpoint and avoid acrimonious debate in the *Journal.*

The 49th SA Medical Congress was an undoubted success and the congress committee is to be congratulated on its achievement. As long as we learn from our mistakes the quality of future congresses can only improve.

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1. Correspondence (1974): S. Afr. Med. J., **48**, 40.