districts there are only two cardiologists. To expect these consultants to be on call at all times for temporary pacing would be unreasonable. To adopt this approach would require an enormous increase in the number of consultant cardiologists in district hospitals (perhaps to four or five). Such an enormous expansion is unlikely to occur.

A more sensible approach therefore, would be to ensure that all SpRs training in general internal medicine receive appropriate training in temporary pacing. Clearly this is not occurring in the region that was surveyed by Dr Murphy. Perhaps all SpRs in GIM should be seconded to cardiac units for a period of time so that they can have greater exposure to temporary pacing. We were certainly surprised that two of the 49 SpRs who responded within two years of completing their training, admitted to never performing a temporary pacing. How could they expect to provide an acute medical service? Surely trainees do have to take some responsibility for their training and should be expected to make local arrangements to correct such local arrangements to correct such large deficiencies in their training.

DAVID M WALKER
RICHARD WRAY
Consultant Cardiologists
Conquest Hospital, East Sussex

Paediatricians should be more interested in adult disease

Editor – Professor Weaver's article (*Clin Med JRCPL*, Jan/Feb 2001, pp38–43) challenges both paediatricians and adult medicine physicians to pay more attention to each other's clinical problems. More and more children with congenital heart disease are surviving into adolescence and adulthood and come under the care of adult physicians who may know little about them or their disease. By the same token, paediatricians may not be fully aware yet of the influence of the mother's health, wealth and nutrition during pregnancy on 'adult' diseases such as hypertension, atherosclerosis, and type 2 diabetes, when their children reach middle age.

ABDULLAH A ALABDULGADAR
King Fahad Hospital
Saudi Arabia

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Statin therapy

In *Who should receive statins?* (The Drug and Therapeutics Bulletin, March 2001, pp21–3) it is stated that statins provide useful benefit in preventing coronary heart disease in those with an absolute risk of 15% or more over 10 years. The writer states that this is not achievable with current NHS funding, and that a more realistic approach is to treat all those with an absolute risk above 30% over 10 years and to extend statin therapy to remaining individuals with a risk level of at least 15% over 10 years, as resources permit. The writer concludes that it is practicable to treat patients without clinically overt atherosclerotic disease only if the absolute risk of CHD events exceeds 30% over 10 years. This fits with government policy.

This 'independent review' from the consumers association does neither consumers or doctors any favours. There is a very real danger that such an approach, particularly when supported by detailed advice on how to calculate risk, will be taken as correct medical practice rather than, as it is, a financial imperative for the government. A patient consulting his doctor still expects that doctor to give the patient the best advice for his or her health. The risk is that the doctor will tell the patient who has perhaps a 15% risk of coronary heart disease over 10 years that treatment with statins is not needed. This is in no way ethically justifiable and I am sure a court of law would agree. To withhold a drug which is apparently harmless, and which will reduce risk from 15% to 10% over 10 years cannot be justified. The only ethical justification for withholding such a drug is if the physician believes that the long-term risk will out weigh the long term benefit.

Physicians are not in practice to decide how the tax payers money should be spent. We are here to help patients. If politicians do not wish to spend taxes on statin therapy then they should pass a law and stand or fall at election as a result.

In the meantime we should continue to do our best for our individual patients; if we do that and it costs money our budget is not overspent it is underfunded and politicians not doctors should take the responsibility.

RICHARD A BEST
Consultant Cardiologist
Burnley General Hospital