letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk

Training in general (internal) medicine alone

Editor – The general (internal) medicine training scheme proposed by Tunbridge, Peto and Scott (*Clin Med JRCPL*, July/August, pp 317–8) is very interesting but one wonders whether or not it provides the training necessary to practise general medicine within the UK. Although the programme includes training in intensive care it does not appear to have any rotation to neurology; patients requiring intensive care probably make up less than 1% of acute medical admissions whereas patients with neurological symptoms comprise 20%[1] and what evidence is available suggests that they are less than perfectly managed by generalists[2]. Without a sufficient increase in the number of available consultant neurologists the care of patients with neurological symptoms admitted to hospital is likely to get increasingly worse as more and more physicians are trained less and less in neurology.

References

1 Morrow J I, Patterson V H. The neurological practice of a district general hospital *J Neurol Neurosurg Psychiat* 1987;**50**: 1397–1401.

2 Craig J, Patterson V H, Rocke L, Jamison J. Accident & emergency neurology – time for a reappraisal. *Health Trends* 1997;**3**:89–91.

VICTOR PATTERSON
Consultant Neurologist
Royal Victoria Hospital, Belfast

In response

We acknowledge that it is desirable to include neurology in any training programme for general (internal) medicine. The reality at present is that most patients with acute neurological problems, including suspected meningitis, stroke, fits and funny turns are seen first by the general medical team on duty in any district general hospital and many teaching hospitals, particularly 'out of hours'. We agree that more consultant neurologists are needed, not only to improve the service for patients but also to provide more training for specialist registrars in general (internal) medicine as well as for those training in neurology.

MICHAEL TUNBRIDGE
TIM PETO
Oxford Radcliffe Hospitals NHS Trust
ROBIN SCOTT
Heatherwood & Wrexham Park Hospitals NHS Trust

Editor – I read with great interest the recent article concerning training in general (internal) medicine alone (*Clin Med JRCPL* July/August 2001, pp317–8). I am currently a second year internal medicine resident at the UCLA Veterans Administration Hospital in Los Angeles, USA. As is pointed out in the paper, it is possible for Board Certified individuals here to continue to practice internal medicine alone. The training program here consists of general medicine rotations with time in both cardiology and general intensive care units, the fellowship programs are also similar in content. These appear to be very similar to the structure of the registrar program in the Oxford scheme.

I am sure that like myself, many post MRCP SHOs who left the UK would not have done so had posts like those described by Dr Tunbridge *et al* been widely available. Unfortunately, the continued shortage of NTNs in almost all medical specialities especially in the south east of England will continue to drive UK graduates abroad. Many of us would ideally love to continue registrar training in GIM alone with emphasis on acute and intensive care, without being forced into specialities by default due to lack of options.

My only concern about the GIM program is where candidates with their CCST would be employed given the lack of such consultant posts in NHS Trusts at present. Given the much publicised shortage of doctors in the UK and supposed expansion in consultant posts, the creation of GIM registrar training posts would almost certainly attract individuals like myself home.

SANJAY VADGAMA
UCLA Veterans Administration Hospital, Los Angeles, US

Conflicts of interest

Editor – As I read Richard Best's clinical letter on statin therapy (*Clin Med JRCPL* May/June 2001, p248) I found myself wondering whether or not he had any conflicts of interest. Does he, for example, have any kind of financial link with a manufacturer of statins? Has he been paid by them to go to conferences? Has he been paid by them to give lectures? Has he had any research funds from them?

I then found myself wondering about the policy of *Clinical Medicine* with regard to conflicts of interest. I would be very grateful if you could make it clear what your policy is and whether Dr Best does have any conflicts of interest. If he does have any conflicts it will not of course undermine what he has to say – but I think that readers have the right to know.

RICHARD SMITH
Editor,
British Medical Journal

In response

After reading my letter opposing present guidelines for lipid therapy on ethical grounds, Richard Smith wonders if I have been paid by a manufacturer of statins. Indeed I have. I have also been paid by manufacturers of hypotensive drugs, ACE inhibitors, angiotensin II receptor blockers, beta-blockers and probably others. Over the years I have received the occasional lecture fee from all these people. I have no regular income from them. I am glad that he realises that this does not undermine what I have to say; I was of course arguing an ethical point not a matter of fact. I am equally enthusiastic about the treatment of hypertension, heart failure and angina; but I haven't written to *Clinical Medicine* about these subjects because as far as I know

nobody has yet produced guidelines which might deprive people of drugs they need on grounds of cost.

RICHARD A BEST
Consultant Cardiologist,
Burnley General Hsopital

Response from the Editor

We are delighted to know that Dr Smith is reading *Clinical Medicine*. He found us wanting. We have already addressed the conflict of interest issue, having now included an appropriate question in the instructions to authors (see back cover of the journal).

PETER WATKINS
Editor, Clinical Medicine

Respiratory failure: two forgotten concepts

Editor – Writing in the CME section of *Clinical Medicine*, Dr Vincent Mak (*Clin Med JRCPL* July/August 2001, pp290–1) quotes the oxygen combining power of haemaglobin as 1.34 ml/g. This figure is frequently quoted but is probably incorrect. Nunn[1] explains as follows:

"Until 1963 the value (oxygen combining power of haemoglobin) was taken to be 1.34 ml/g. Following the precise determination of the molecular weight of haemoglobin, the theoretical value of 1.39 ml/g was derived and passed into general use. However, it gradually became clear that this value was not obtained when direct measurements of haemoglobin concentration and oxygen capacity were compared. After an exhaustive study of the subject, Gregory[2] proposed the value of 1.306 ml/g for human adult blood."

References

1 Nunn JF. *Applied respiratory physiology* (3rd edition). Cambridge: Butterworth, 1989.
2 Gregory IC. The oxygen and carbon dioxide capacities of foetal and adult blood. *Journal of Physiology* 1974;**236**: 625.

MARK HARRIES
British Olympic Medical Team

Fever of unknown origin

Editor – I read with interest the article on fever of unknown origin (*Clin Med JRCPL* May/June 2001, pp177–9). In their introduction the authors state that this descriptive term was first used in 1961. While this may be true of 'FUO', the diagnosis of 'pyrexia of unknown origin' is of much earlier vintage. During the First World War, many cases of fever of obscure origin were reported among the troops serving in France and this gave rise to much concern in the army medical services. The illness was said to be rarely fatal but to give rise to much disability among the fighting men. A committee formed to study the problem published its findings in the *British Medical Journal* (*BMJ* 19th Jan, 1918: pp91–5), describing the clinical features of 'PUO' (also referred to as trench fever) and pointing out that this was much more common than that ancient scourge of war – enteric or typhoid fever. On the whole the prognosis seems to have been good, with half the men returning to active duty while the rest were evacuated and further follow up is not stated. I hope that this minor historical footnote may be of interest to readers of the journal.

RAYMOND RAULT
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