

unnecessary CSF assays. We also believe that until results of such studies are available it would be prudent for clinicians to continue to request viral PCR assays on adults as well as children with suspected CNS infections. Nonetheless a proportion of adults present predominantly with headaches (without other features of encephalitis or CNS infections) and it may be appropriate in some cases not to order CSF PCRs if CSF parameters are normal and symptoms improve or resolve rapidly. One of the benefits of a retrospective study such as ours, albeit a relatively small study, was being able to determine eventual outcomes and also assess readmissions of patients. Although readmissions were not discussed in our manuscript, it was evident that there were no patients readmitted with features of CNS infections or suffering significant morbidity due to missed CNS infections following negative PCR results, and this gives some credence to a potential strategy of deferring or avoiding PCR tests in a subset of patients with normal CSF.

We would take issue with the assertion that because 'in herpes simplex encephalitis there was no CSF pleocytosis in 11% of cases in a recent UK study',¹ this always mandates testing CSF samples for HSV PCR where there are normal CSF parameters. The study they cite had a case definition of altered consciousness, irritability or behavioural change, and these features probably occur in a minority of adults admitted acutely who undergo lumbar punctures.

Reference

- 1 Granerod J, Ambrose H, Davies N *et al*. Causes of encephalitis and differences in their clinical presentations in England: a multi-centre, population-based prospective study. *Lancet Infect Dis* 2010;10:835–44.

YAASIR MAMOOJEE
Foundation trainee

DAVID CHADWICK
Consultant in infectious diseases
Department of Infection and
Travel medicine,
James Cook University Hospital,
Middlesbrough

Lessons of the month

Editor – Rapid availability of blood and serum results helps clinicians to make immediate bedside decisions, but their interpretation continues to pose challenges in clinical practice as witnessed in the two interesting cases of high educational value in the 'Lesson of the month' published in the December issue (*Clin Med* December 2011). For nephrologists, absolute numbers of blood and fluid parameters along with their trends are paramount. We would like to share additional learning points out of these two cases.

In the first case, severe hypomagnesaemia (<0.1 mmol/l) caused seizures. If this result is viewed as a reflection of the fact that there is only 1% of the total body magnesium in the extracellular space, this would have provided a fuller picture of absolute magnesium deficiency, as the renal and gut mechanisms would have failed to correct extracellular magnesium in the long term. This information could have translated into maximal initial correction of serum magnesium using 2 mmol/kg IV dose, a repeat serum magnesium check in a week or two by the GP and then timely oral magnesium supplementation if required. A normal PTH may still be abnormal as PTH resistance is common in magnesium deficiency. A normal 24 hour urinary magnesium in someone during severe magnesium deficiency may not add further valuable information.

Similarly, if the second case of normal corrected calcium and tetany was viewed in terms of the compartments of total serum calcium, this, applied to someone acutely vomiting and losing acid, would help identify the pathology early and allow appropriate management using the right fluid initiated without adding further insult to the injury.

These broad principles are not limited to these cases, but can be applied to most biochemical test results if interpreted as reflections of the concentration in the accessible 10% extracellular fraction of the total body water. Recognition of this volume model of body composition is increasingly applied in correction of electrolytes, minerals and fluid homeostasis due to major chronic conditions like heart failure, chronic

kidney disease and chronic liver disease.

AZHARUDDIN MOHAMMED
Specialty registrar in nephrology

SIMON FLETCHER
Consultant nephrologist

University Hospital Coventry,
Coventry

Let's hear it for the medical registrar

Editor – In the December 2011 issue of *Clinical Medicine*, you mentioned in your own editorial, 'Let's hear it for the medical registrar' (*Clin Med* December 2011 pp515–516), the issue of involvement in the acute take and the role of the generalist in hospital general internal medicine. In the same issue, Goddard and colleagues reported a national survey of medical registrars' experience and attitudes to their future careers – in particular, the reluctance of nearly half of them to continue active involvement in the acute take on becoming consultants.¹ Here too, the issue of generalism versus specialism was raised. I believe that this needs further reflection and exploration before we rush headlong to the creation of 'hospitalists' (in other words, re-creation of general physicians), for a number of reasons.

1. We already have what is probably the most extensive training in general internal medicine of any health system: two years at CMT level, rotating through several specialties, followed by five or six years higher specialty training, with GiM dual accreditation throughout for many CCST holders. Are we proposing even longer or more rigorous training in General Internal Medicine? Will 'hospitalists' be any better trained in GiM than current dually accredited consultants?
2. With the expansion of acute medicine as a specialty, as well as a growing focus on medical admission units with very intensive 'front door' involvement of consultants, is there a large cohort of patients remaining in hospital beyond 48 hours who don't fit fairly comfortably into one 'organ specialty' or other, as defined by their principal presenting

illness (albeit often alongside various long-term co-morbidities)?

3. The majority of acutely admitted adult patients are older – often among the oldest of old, and often with multiple long-term conditions, frailty and complex co-morbidity. For instance, 1 in 4 adult beds is occupied by someone with dementia.² Geriatric medicine – the largest GiM specialty of the Royal College of Physicians – deals well with these patients and there is an excellent evidence base for the effectiveness of comprehensive geriatric assessment³ (the skill that geriatricians offer) as well as for the care of individual syndromes related to old age such as delirium, falls, or incontinence. So either we need more geriatricians or we need to ensure that all general physicians have competencies in care of frail older people with multiple co-morbidity.
4. In the scenario described in the articles to which I refer, of an acute receiving physician who cares for a big portion of acutely admitted GiM patients, calling on specialty consultants could lead to an unfulfilling role of notional responsibility, where one's name may be above the bed, but, in reality, one is waiting daily for specialty advice from another team before a decision can be made. Such 'remote control' management can be frustrating and might be an unattractive prospect – in its extreme form turning the generalist into an 'intern' for the visiting specialist.
5. Provocative though this may sound, I can't help wondering whether doctors paid by and trained at length by the NHS should take pride in looking after the patients who come through the door, rather than those whom they might find more intellectually stimulating or rewarding to look after.

The business of acute hospital medicine in the twenty-first century is not all high-tech, cutting-edge or curative, but the management of (generally older) patients with (generally multiple) commonplace long term conditions, often a degree of physical disability, cognitive impairment or social vulnerability and often needing a multidisciplinary approach which deals not merely with disease, but bio-psycho-social factors,

rehabilitation and maintenance. If physicians working in adult medicine don't feel confident or willing to look after such patients or, worse still, label them as 'social' or 'acopia',⁴ we need to tackle this in training, in job planning and in appraisal and management. Our values, priorities and skills need to catch up with this reality. Something has gone wrong if nearly half the doctors who have chosen to train extensively and expensively in general internal medicine conclude that they don't then want to practice it.

DAVID OLIVER
Consultant physician

*Geriatric and General Internal Medicine
Royal Berkshire NHS Foundation Trust*

References

- 1 Goddard AF, Evans T, Phillips C. Medical registrars in 2010: experience and expectations of the future consultant physicians of the UK. *Clin Med* 2011;11:532–5.
- 2 Alzheimer's Society. *Counting the Cost. Caring for People with Dementia on Hospital Wards*. London: Alzheimer's Society, 2010.
- 3 Stuck AE, Iliffe S. Comprehensive geriatric assessment for older adults. *BMJ* 2011;343:d6799.
- 4 Oliver D. Acopia and social admission are not diagnoses. Why older people deserve better? *J Royal Soc Med* 2008;101:168–74.

The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards – effect on training?

Editor – While the reduction in the average length of stay and the increase in the number of discharges observed following the transition from twice-weekly to twice-daily consultant-led ward rounds described by Ahmad *et al* (*Clin Med* December 2011 pp 524–528) is admirable, we are concerned about the impact this change would have on training. In the same issue of *Clinical Medicine*, results of a 2010 survey of medical registrars showed high levels of dissatisfaction with UK training due to the impact of the European Working Time Directive (EWTD)¹. It

would thus have been informative to include some reflection from trainees within the team on the effect of the changes on training and job satisfaction.

There has always been a dichotomy between training and service provision in UK postgraduate medical education, with perceived training inadequacies highlighted during successive postgraduate structural reforms.^{2,3} Increasing consultant-led ward rounds and EWTD-compliant rotas leads to a reduction in learning opportunities for trainees, with the doctors involved in initial patient assessment not necessarily present on post-take ward rounds.⁴ Additionally, there is a perceived reduction in trainee autonomy when post-take ward rounds occur before the admitting doctor is able to institute a management plan.⁵ Feedback from trainees indicates that only a small proportion of junior doctor learning occurs on ward rounds⁶⁻⁷ and specialist registrars (SpRs), especially in their latter years of training, value the opportunity to lead ward rounds in order to develop leadership and decision-making skills prior to consultant appointment.⁶ Furthermore, supervision and review of cases clerked by junior colleagues is an essential part of the development and training of SpRs.⁸

Whilst the change to twice daily consultant-led ward rounds may improve patient outcomes in the short term, we wonder whether this would lead to a further erosion of training opportunities for junior doctors and what would be the longer-term impact on the quality of future consultants.

LYDIA ECCERSLEY
*Clinical research fellow,
Imperial College*

*London and Honorary SpR in
Haematology,
Imperial College Healthcare NHS Trust*

LIONEL TAN
*SpR in Infectious Diseases and General
Internal Medicine,
Imperial College Healthcare NHS Trust*

References

- 1 Goddard AF, Evans T, Phillips C. Medical registrars in 2010: experience and