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 assessment[3] (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.

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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 rounds[6-7] 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.

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Offering HIV testing in an acute medical admissions unit in Newcastle upon Tyne

Editor – Ellis and colleagues' study provokes much thought with regard to acute admissions units and their role in asymptomatic disease diagnosis (*Clin Med* December 2011 pp 541–43). The concept of screening all patients for treatable diseases is attractive but may generate more dilemmas than solutions. The difficulty comes in choosing the diseases to screen. In the United Kingdom human immunodeficiency virus (HIV) has a prevalence of 0.15% (86,500/61,400,000).[1] This is less common than other blood born viruses, in particular hepatitis B 0.3%[2] and hepatitis C 0.4%.[3] Can we routinely test them all, and if so, is an acute admissions unit really the best place for screening?

The rate of HIV testing in the study was low. Just one in eight (478/3753) admissions were offered a test. It would have been interesting to know the characteristics and admission time of the 3275 patients not offered testing. The authors highlight that in Newcastle a large proportion of patients with a new diagnosis of HIV present late with a CD4 <200 cells/ul.[4] Furthermore, 50% of these patients had been seen by healthcare professionals with diseases suggestive of HIV. Both cases detected in the study were late presenters with AIDS-defining infections. Thus, of 3,753 admissions, no early diagnosis in asymptomatic individuals was made. The reported specificity of the Enzyngost HIV integral II test is 99.93. Had all 3,753 admissions been tested, 2 individuals would have had a false positive result (only 3 less than the 5 presumably missed cases (where the HIV prevalence is 2 per 1000)).

Population screening is a contentious issue which this study further highlights. Targeted testing (in patients at high risk of blood borne virus infection) particularly in relatively low prevalence conditions is perhaps a more favourable alternative, although a lot of patients with such diseases fail to engage in the standard models for healthcare, posing a further challenge to the screening process. It may be more appropriate to screen patients in primary care as part of a new patients registration visit permitting earlier diagnosis and treatment. This study questions the utility of HIV testing in an acute medical admissions unit.

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In response

Editor – We agree with Drs Thomas and Cross that offering HIV testing in primary care to patients with indicator diseases is more likely to reduce late diagnoses, and this recommendation is in line with the recent NICE guidance.[1,2] The main barrier is the medical practitioner, as many are unaware of situations in which HIV testing is recommended or feel uncomfortable and uneducated with respect to offering HIV testing. Blood borne viral testing for hepatitis B and C should be considered at the same time.

While the current testing guidelines constitute a significant change in clinical practice in the approach to HIV testing, it would only be successful in reducing undiagnosed infection and late diagnosis if the general clinical community and the population at risk embraced the recommendation and HIV testing is demystified.

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