

letters to the editor

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Sustainability of MBPhD programmes

Editor – The decision to enrol in an MB/PhD programme can be daunting for most students at the start of their medical degree. Exceptions may well be those who have previously performed research or those who come from a family background of academia or research. Asking students to commit themselves to a defined pathway at the start of their medical course is only productive if there are clear professional pathways for them to follow on graduation, such as the programme at Harvard University.¹ Both the Cambridge and UCL programmes (*Clin Med* December 2012 pp526–9 and pp530–4) have been successful in terms of completion rates, as the students are selected on the basis of showing evidence of academic aptitude at tertiary level.

Various models of this have been introduced in Australian medical schools, with less successful outcomes. In one of our most prestigious medical schools the model has evolved twice. In the original plan, 30 students were selected into a specific MBBS/PhD stream at the time of entry to medical school. In the first cohort, none of the students commenced the full time research component of their programme, instead appealing to complete their clinical studies with their peers. This was then changed to an average of five students enrolling in the combined program with appropriate financial and academic support.² However, as these graduates still had to enter the same pathways for postgraduate training as all other medical graduates, suitable potential students progressively lost interest. They also had competition from colleagues who undertook higher research degrees in their chosen specialty topic towards the end of their specialty training. This medical school has now removed the MBBS/PhD entry

pathway and now enrolls all their students in the MBBS programme with the option of undertaking research during their course, leading to a master's degree, with the potential to expand this for the few who have the aptitude and ability to do so.³

In summary, encouraging high-performing students to enrol in a combined professional and research medical degree can only be a sustainable way to develop skilled clinician scientists if postgraduate pathways to academic medicine are clearly defined. However, this pathway should be flexible to admit doctors who opt to undertake research during their postgraduate training.

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References

- 1 Harvard Medical School. 5.01 MD-PhD Program. <http://hms.harvard.edu/departments/office-registrar/student-handbook/5-combined-degree-programs/501-md-phd-program> [Accessed 1 February 2013].
- 2 Power BD, White AJ, Sefton AJ. Research within a medical degree: the combined MBBS-PhD program at the University of Sydney. *MJA* 2003;179:614–6.
- 3 The University of Sydney. Master of Philosophy in conjunction with Sydney Medical Program. <http://sydney.edu.au/medicine/future-students/medical-program/combined-masters-programs/philosophy.php> [Accessed 1 February 2013].

The virtual bronchoscopy simulator – a young physician's view

Editor – I enjoyed reading Emily Heiden's account of how she has used an online 'virtual bronchoscopy' tool in her training (*Clin Med* December 2012 pp 609–10). I

also made use of this excellent resource to help learn the anatomy of the bronchial tree before going on to practice the technique for real. I was surprised, however, that she did not mention the 'quirk' of using this particular simulator. The virtual bronchoscopy in question is conducted from the point of view of an anaesthetist, who is presumably stood behind the head of a supine patient, while respiratory physicians tend to perform their bronchoscopy standing by the side of a patient who is sat upright. The anatomy of the airways seen through the bronchoscope is therefore rotated 180 degrees in relation to the images learnt in the online tool, and the trainee must perform some mental acrobatics to orient things correctly (or rotate their computer display when practicing at home!)

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Community-acquired pneumonia and welding

Editor – We read with interest the recent review of community-acquired pneumonia (CAP) (*Clin Med* December 2012 pp 538–43) and write to draw attention to a relatively neglected risk factor for CAP that physicians may wish to learn about.

Relative to their social class peers, welders have been dying of pneumonia in excess for at least eight decades.¹ Evidence for this comes mainly from successive national analyses of occupational mortality in England and Wales, which have clarified that risk particularly relates to lobar and pneumococcal pneumonia, and is short-term and reversible (evident in current welders but not in retired welders).^{2,3} Welders are also more commonly admitted to hospital with CAP, especially lobar pneumonia, as demonstrated by a large case-control study from the West Midlands.⁴ Risks in relation to microbiologically confirmed pneumococcal infection tripled, although were also apparent for a range of other microorganisms, including *Legionella*, *Mycoplasma* and *Haemophilus influenzae*.⁴ Similar reports relating to lobar and pneumococcal infection in welders subsequently emerged from Sweden⁵ and Canada.⁶