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 enrols 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.

DA KANDIAH
Faculty of Medicine, Dentistry and Health Sciences University of Western Australia, Australia.

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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!)

DANIEL HOLYOAKE
Specialty registrar in clinical oncology
Addenbrooke's Hospital, Cambridge

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 Sweden[5] and Canada.[6]

Britain has some 70,000 at-risk workers in welding occupations. Other at-risk groups include a range of workers who share occupational exposure to metal fumes in common (eg moulders and core makers, and furnace men in foundries).[2,3]

In response to growing evidence on risk, the Joint Committee on Vaccination and Immunisations (JCVI), on behalf of the Department of Health in England, recommended in 2011 that all welders be offered a single dose of the pneumococcal polysaccharide vaccine PPV-23.[7] This advice was modified in 2012, extending recommended use to a broader range of workers with exposure to metal fumes. Further details and a discussion of the potential strengths and limitations of PPV-23 vaccination in at-risk occupations have been published elsewhere.[1]

KEITH PALMER
Professor of occupational medicine

MRC Lifecourse Epidemiology Unit, University of Southampton

MARTIN COSGROVE
Consultant occupational physician

Cherry Hinton Medical Centre

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Tissue and organ donation guidance

Editor – We read with interest the two articles relating to the BMA and NICE guidance around tissue and organ donation (*Clin Med* December 2012 pp 513–6 and pp 517–9) and the debate that they have generated. While the ethical and moral debate is undoubtedly of great importance, we would like to point out an omission from the NICE guidance surrounding opportune times to check a patient's wishes in this respect. Currently in the UK people can opt to join the National Organ Donor Register (ODR). People are also offered this opportunity when applying for a driving licence. Doctors, however, cannot easily check if a patient is on the register. We suggest that hospital admission offers an opportunity to check patient preference and that donation status be included or checked as part of initial hospital triage. We are not suggesting that doctors should ask patients with any coercive intention, but merely provide an opportunity for a patient to have their wishes recorded or for clinicians to provide more information if requested. To our knowledge only one UK hospital trust routinely asks if patients are on the ODR on admission to hospital.[1] We would suggest junior doctors do not spontaneously ask this question on admission, based on a recent survey that we performed in our trust.

We conducted a survey of junior doctors working in surgery, general medicine and emergency medicine in a large district general hospital to investigate the knowledge and beliefs around organ donation, and whether this may help to explain the trust's low organ donation rates. 53 doctors were asked five knowledge-based questions and three questions around their confidence in discussing tissue and organ donation on five point Likert scales (1 = not confident at all, 5 = very confident). All questions were answered anonymously. Not a single junior doctor surveyed routinely asks if patients are on the ODR. While most were aware that some tissues can be donated post mortem, only 6% knew that some tissues are viable for up to 48 hours post mortem. Only 19% would describe themselves as quite or very confident (4 or 5) discussing donation with patients and families, although they would be more confident (32%) in asking if patients were on the ODR at admission.

It is estimated that about 52% of patients on the ODR have not informed their next of kin.[2] Surely in an era where patient choice is paramount, clinicians have a moral obligation to ensure that patient wishes are checked and recorded so that difficult discussions in traumatic circumstances can be avoided. Merely asking whether a patient is on the ODR at admission could potentially open a discussion about organ donation without placing undue pressure on a potentially vulnerable patient. We suggest that with training and education, doctors could help in not only raising awareness of this important issue, but ensure that the patient has been able to maintain their own choice in the situation where organ donation or tissue donation could occur.

TOM PAIN
ST4 acute medicine

NATALIE POWELL
Consultant in acute and stroke medicine

East Surrey Hospital

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