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.

Women in hospital medicine

Editor – We would like to raise several points in reply to the editorial by Elisabeth Paice on women in hospital medicine (*Clin Med JRCPL*, September/October 2001, pp344–5). At present our department caters for three flexible training SpRs whose experience of these posts has been positive both in response from colleagues, and in enjoyment of our own work. The key to our success is teamwork: time for communication and handover is essential to maintain patient management, and to avoid isolation of the flexible trainee. Far from finding resentment from colleagues, we have found people happy to share workloads, in both the specialty and acute general medicine, with no resentment towards our pay. Full-time SpRs have been interested in the way we can direct our training towards our own objectives, and seem to use this positively towards their own career goals.

However, our jobs do create extra work for the educational supervisors, which is not recognised in their own workload. Also, clarification is needed from the Royal Colleges about the RITA system with flexible trainees. Often, the specialist training committee is not clear how much training has been done, and whether the work counts. It is frequently left to the trainee to spend considerable time checking on whether a job fulfils training criteria; a situation that favours the full time SpR for whom it is already worked out.

We agree that the new pay structure has created inequalities and certainly does not encourage trusts to employ supernumerary trainees. The *pro rata* band Fc, for jobs involving only daytime hours, appears a fair option, but care has to be taken that training in acute medicine is met. Funding for Fc banding is met centrally. Hardly surprising then, that trusts hesitate to employ trainees if a job involves out-of-hours work, thereby moving the trainee from Fc to Fb or Fa bands, where the trust pays. A few flexible SpRs are in Band 3 as they partake in an internal rota. Here the emphasis should be to change the rota as a whole to a less intense system, rather than the trust denying on-call experience to the flexible trainee. Finally, Fa and Fb banding for jobs with out-of-hours commitment are set payments, irrespective of how many sessions the trainer worked in daytime hours; surely a ridiculous situation compared to *pro rata* payments.

In the future, as more women choose flexible training, we agree with the author that trusts will wilt at paying for supernumerary posts, and more job shares should be encouraged. In a teaching hospital, which SpRs rotate into, fixed posts for flexible trainee sessions could be introduced into the popular or broad specialities such as general medicine.

Most importantly, we need to work with trusts to encourage them to employ flexible workers at SpR and consultant level, so that doctors are not lost to the profession. Flexible trainees are highly motivated workers, adept at juggling several issues at once and who have, through their own needs, become good at prioritising. All qualities demanded in the future consultant-led NHS service.

C CAMPBELL
M HASELDEN
V QUAN
Specialist Registrars
C RAYNER
Consultant in Thoracic Medicine and General Medicine
St George's Hospital, London

Duplicate publication

Editor – We are writing to express our unease at what we believe is inappropriate censure imposed on our colleague Professor Corris (*Clin Med* JRCPL November/December 2001, p430 – see also *Thorax* 2002;57:6) concerning duplicate publications. Professor Corris was asked to write what was essentially a CME article for *Clinical Medicine* on a subject that he had recently reviewed in detail for *Thorax*. It was inevitable that there would be considerable duplication. The same papers and information were being discussed and there are limitations in the way complex arguments can be expressed. It is universally accepted that a degree of duplication in review articles is completely different from trying to pass off as a new study previously published, peer-reviewed papers containing original data.

It is commonplace for people with authoritative opinions to write similar articles in more than one journal as shown by the similarities between the Harveian Oration by Professor Warrell published in the same issue of *Clinical Medicine* (*Clin Med JRCPL*, November/ December 2001, pp485–94) and in the *Lancet* (2001;358: 1983–8).

We believe such duplication is entirely appropriate as surely it is our duty as educators to disseminate information to as wide an audience as possible. Fraud in any shape or form in science is to be wholly deplored, but let us not be so zealous in its pursuit that we smear the innocent to the detriment of us all.

At risk of another duplicate publication, we have also sent this letter to the editors of *Thorax*.

IAN D PAVORD
MICHAEL DL MORGAN
ANDREW J WARDLAW
Department of Respiratory Medicine and Thoracic Surgery,
Glenfield Hospital, Leicester

RCP Consultant Questionnaire Survey

Editor – In their discussion of the third RCP consultant questionnaire, Mather and Connor infer that 'the acute medicine component is evidently less popular than non-acute duties, with 30% of physicians expressing a desire to opt out of the 'take' rota'[1]. As a respondent who expressed such a desire, I suggest that it may not be acute medicine *per se* that is the problem.

I enjoy being on call for acute medicine. The clinical challenges presented, including interpretation of history, physical signs and limited laboratory data often in difficult circumstances, are intellectually stimulating. The extraordinary diversity of

fellow beings each in various degree of medical need provides endless fascination. The opportunity to explain diagnosis and treatment to the concerned, the bewildered, the frightened, the truculent and the frankly antagonistic is never boring. To communicate, however briefly and at whatever level of understanding, with the confused or demented provides a moment of shared insight, possibly for both participants.

My objection to acute medical takes lies in what happens thereafter. I can anticipate that it will be impossible to transfer my patients to an appropriate specialist ward. I will be required to accept clinical responsibility for medical problems in which I do not claim to be expert, in a clinical environment that I believe to be inappropriate. I know that the moribund or immobile patient may lie unattended for hour after hour because of a lack of nursing staff. I know that my patient is liable to be transferred from ward to ward during his or her admission, because of insufficient medical beds in the hospital. I know that this phenomenon will be referred to as 'sleeping out' or 'outliers' – an administrative euphemism that belies the reality of disrupted continuity of care for frail, distressed patients and their relatives.

In short, when I am on the acute take rota, I feel like the gatekeeper for second-rate and amateur healthcare delivery to some of the most acutely ill patients in the hospital. In these circumstances, it is perhaps understandable that physicians such as myself express a preference for non-acute duties.

Reference

1 Mather C, Connor H. *The Third RCP Consultant Questionnaire Survey.* 2002 (unpublished).

DAVID BENNETT-JONES
Consultant Physician/Nephrologist
North Cumbria Acute Hospitals NHS Trust
Cumberland Infirmary, Carlisle

General practitioners with special clinical interests

Editor – We read with interest the recent editorial on general practitioners with special clinical interests (*Clin Med JRCPL*, September/October 2001, pp346–7).

At the Royal Infirmary of Edinburgh we have developed the primary care GP physician role in acute medicine. This post is complementary to the consultant physician input in the medical assessment unit but focuses on the management of those patients with complex needs, primarily the frail elderly.

The GP works closely with the multidisciplinary team to achieve a medical diagnosis and, more importantly, a prompt functional assessment of the patient. This approach permits safe placement in an appropriate care setting, with a significant proportion (at least 30%) returning directly to a primary care setting.

This is only possible with understanding and close liaison with the primary health care team. The close partnership is achieved with sessions in a local general practice providing general medical services both within the surgery and through working for one of the out-of-hours co-operatives. In the practice the skills developed in the acute setting are used both formally and informally and usually relate to elderly patients.

In addition there is a session in medical outpatients, which is designed to accept referrals from local general practitioners and review them promptly. The clinic also provides follow-up of selected patients discharged from medical assessment.

A formal framework of continuing professional development and education is in place via the Royal College of Physicians CME scheme and symposia combined with selected postgraduate general practice meetings, plus active membership of the Society for Acute Medicine (UK) which also promotes the input of general practitioners to acute medicine.

In effect the post blends the models outlined in the document entitled *General practitioners with special interests*[1] with provision of service within and across primary and secondary care.

This post promotes primary care involvement in the emerging specialty of acute medicine, and in crossing the primary–secondary care boundary promotes high quality, seamless patient care.

Our experience leads us to believe that such posts would be a significant addition to existing practice, in line with the philosophy of the document, but as yet few if any comparable posts are established.

This post is an excellent working example of innovative patient care provision which integrates with, rather than substituting for, consultants but provides a more holistic approach to patient care and an opportunity for future general practice diversification in a unique direction.

References

1 Royal Colleges of General Practitioners and Physicians. *General practitioners with special clinical interests.* London: RCGP, 2001.

ALASTAIR CROSSWAITE
Patient Services Director
DEREK BELL
Primary care physician
Lothian University Hospitals NHS Trust

Tuberculosis – a missed opportunity?

Congratulations on publishing such an excellent summary of the current problems of tuberculosis (*Clin Med JRCPL*, January/February 2002, pp55–8).

Dr White details the Leicester school outbreak. There is an important possible contributing factor to this outbreak, which has so far not been mentioned, either in this article or in others about it[1].

Unlike most authorities treating tuberculosis and latent tuberculosis infection (also called subclinical infection), and in contravention of current guidelines[2], Leicester has never pursued a policy of giving comprehensive preventative therapy. The grounds for failing to do this have been published but are somewhat tenuous[3].

As an earlier article states, any protection given by BCG in these school children, aged more than 13 would be waning[1]. This is because, as ethnic minority children, they would have received BCG at birth and it is known to provide protection for only 15 years. If a substantial proportion of children at the school had latent tuberculosis infection, a small amount of added infection received through school contact with an infectious case could have tipped a number of students into having the active disease. It is possible that the failure to use preventive therapy in Leicester has been a contributing factor to the biggest outbreak of tuberculosis in at least the last 25 years.

References

1 Watson JM, Moss F. TB in Leicester: out of control or just one of those things? *Br Med J* 2001;**322**:1133–4.