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1 Mather C, Connor H. *The Third RCP Consultant Questionnaire Survey*. 2002 (unpublished).

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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.

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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.