the only effective sanction would be to switch off the radio and television and not to read newspapers. Like the flavours in some junk foods, they possess habituating constituents – scandal, bad news – and their hold over the population is likely to increase. If they cannot curb themselves and promote further the credulousness and self-regarding selfishness of society they will destroy what they claim to champion. Baroness O'Neill has performed an important service for British society; its impact may be gradual and we must be patient. However, greater forces are marshalled against her. The House of Lords is being modernised – too independent, Oxbridge Colleges are too elitist, philosophers live on a different planet and medical royal colleges need taking into public ownership in the Postgraduaute Medical Education and Training Board. Nonetheless, when going into the jungle I know whom I – and most of the population – would wish to accompany us. Trust the people.

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3 Black DAK. Book review, autonomy and trust in bioethics. *J R Soc Med* 2002;**95**:423–4.

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.

Are preventive drugs preventive enough

Editor – The study by Trewby *et al* (*Clin Med* November/December 2002, pp527–33) is a thought-provoking investigation of patients' expectation of benefit from preventive drugs. The authors demonstrate a mismatch with the actual benefit that can be calculated from the major clinical trials of cardioprotective drugs. However, it may be argued that it is not valid to compare the 'expected' and 'actual' benefit directly in this way.

Clinical trials are designed to determine whether a drug has any statistically significant benefit to the population in question. The statistical power of the trial increases with the number of subjects; the primary outcomes studied are usually the 'hard' statistics such as myocardial infarction and mortality. The absolute and relative risk reduction are derived figures that relate only to the outcome measure. However, absolute risk reduction may not 'answer the individual's main questions' as the authors assert.

In reality, benefit is not a binary outcome. A drug that lowers cholesterol and reduces the risk of myocardial infarction and death may well also reduce the risk of angina, cardiac failure, stroke, renal failure and many other outcomes which a patient may consider important. The risk of adverse effects is also important; for example, a statin would be less likely than a beta-blocker to produce the 'awful side effects' cited by one subject. A patient may summate all these potential benefits and adverse effects in a non-linear and highly individual way; to present a numerical 'benefit' relating to a single outcome is an oversimplification.

The populations studied in the large trials are heterogenous, and no trial has the power to provide reliable figures on the likelihood of all possible outcomes given any possible combination of relevant risk factors. However, in clinical decision-making a clinician combines quantitative with qualitative information to provide patients with recommendations that may be much stronger than figures derived from clinical trials may suggest.

'Taking the patient's views into account when prescribing' could also be misinterpreted by the patient as lack of conviction on the doctor's part. As doctors, our ethical responsibility is to advise our patients as best we can, clearly stating which measures will give the patient the best chance of health in the future. Whether the patient dislikes the idea of taking tablets is a separate issue; in fact, the patient holds the ultimate power in choosing whether or not to follow medical advice. It could be argued that medical paternalism and other power metaphors are less important in today's information-loaded society, and that the most important aspect of a patient-centred, evidence-based approach is to explain to the patient the scope and limitations of the evidence, rather than simply to provide the available data.

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Diagnosis and management of gastrointestinal causes of chest pain of uncertain origin – 'oesophageal angina'

Editor – The helpful account by Dr de Caestecker (*Clin Med* September/October 2002, pp402–5) draws attention to a

common problem – investigation and diagnosis of the cause of chest pain. William Heberden's first description of the symptoms of angina pectoris in 1768 makes reference to both its association with swallowing and to the risk of sudden death. Unfortunately, the oesophagus is often not even considered as a cause of the pain when cardiac investigations are normal.

We have long held the view that one should use and teach the term 'oesophageal angina' so that it will readily come to mind in this clinical situation. Whilst the identification of abnormal oesophageal function against a background of normal cardiac investigations does not entirely resolve the problems, it does reassure the patient and reduces the number of emergency admissions for chest pain, as well as the number of cardiac investigations, including coronary angiograms.[1]

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1 Swift GL, Alban-Davies H, McKirdy H, Lowndes R *et al*. A long-term clinical review of patients with oesophageal pain. *Q J Med* 1991;81:937–4.

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Sir Douglas Black (1913–2002)

Editor – Whilst working as a Lecturer/Senior Registrar on Douglas Black's unit at the Manchester Royal Infirmary in the early 1960s, I would routinely follow up the Professorial ward round by an evening discussion with the patients on the ward.

I recall one patient, clearly having some rudimentary knowledge of Douglas's studies and writings on electrolytes, told me that he had been impressed by the Professor's reassurance on his condition, albeit delivered *sotto voce*. He then added 'in any case I have been told that he is the best electrician in the world'!

The humorous aspect of this remark would not have been lost on the usually serious, yet ever witty Professor.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Senior house officers in medicine are still not getting adequate appraisals

With the publication of the report *Unfinished business: proposals for reform of the senior house officer grade* by the Chief Medical Officer for England, the need for reform to the SHO grade is now considered a priority.[1] The success of these reforms in improving the training of SHOs will depend on regular and continual appraisals. In *A curriculum for SHO training – what is it and why has it changed?* Carty *et al* draw attention to the revised core curriculum for SHOs in medicine and the medical specialties.[2] Only 40% of SHO posts included regular appraisal. A new appraisal portfolio based on the revised curriculum had been produced. This appraisal portfolio, which consists of the *Core Curriculum and Appraisal Record* presented in a single folder, has now been available for more than 12 months.[3] It was produced with the aim of helping SHOs to develop personal training plans and help them to identify, together with their educational supervisor, their training requirements.

A recent survey among 50 SHOs in medicine at Derriford Hospital, Plymouth to ascertain their experiences and attitudes to the appraisal process and the RCP appraisal portfolio, revealed that 50% had never read the Core Curriculum and only 5% always read the Core Curriculum before or during a post. Only 54% had the RCP Appraisal Record of whom 30% updated them annually or less frequently. The survey showed that 32% had not had any appraisals at any time and 74% of SHOs had appraisals on 50% or less occasions at the beginning of their posts. Of the SHOs who had been in two or more posts 57% had appraisals on 50% or fewer occasions in their final month in a post. Eighteen per cent of SHOs did not know who their educational supervisor was. Eighty per cent agreed that it was their own responsibility to arrange appraisals but 20% felt it was either the educational supervisor's or a joint responsibility to arrange appraisal meetings. This is despite regular interviews with the college tutor and written reminders.

There is clearly a need for SHOs to be made more aware of their responsibility to arrange appraisals and obtain the new edition of the *Core Curriculum and Appraisal Record*. The appraisal record contains documentation to use for appraisal and a learning experience portfolio to identify training needs, and greatly assists the appraisal process. Perhaps the Royal College of Physicians ought to receive documentary evidence of satisfactory appraisal before completion of General Professional Training.

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3 Royal College of Physicians. *Core curriculum & appraisal record for senior house officers in general (internal) medicine and the medical specialties*. London: RCP, 2001.

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In response

This is an important survey and its appearance in this journal is timely. It is interesting that although 80% of SHOs recognised that it was their own responsibility to