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]

References

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Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section.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.

References

1 Department of Health. *Unfinished business – proposals for reform of the senior house officer grade*. A report by Sir Liam Donaldson Chief Medical Officer for England. London: DH, 2002.
2 Carty E, Neville E, Pembroke MA, Wade WB. A curriculum for SHO training – what is it and why has it changed? *Clin Med JRCPL* 2001;1:50–3.
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