other factors that distinguished those who won from those who did not makes fascinating reading.

Although much has been written about individual Nobel scientists and the topics that led to their awards, this is the most comprehensive, readable and informative account. One is left with a better understanding of the complexity of the selection process and of the inspiration, motivation and perseverance that lie behind great science, and also with an appreciation of the fine line that distinguishes winners from losers. Eugene Garfield said that 'evaluating Nobel science is like comparing a masterpiece by Rembrandt to one by Matisse.' Somewhere along the line judgement is needed, not about whose work is better, but about whose work is likely to make the most impact. The amount of science being carried out in laboratories throughout the world by hugely talented scientists must lead to occasional arbitrary choices, but very, very few of those who have won the prize have not deserved it.

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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: Clinicalmedicine@rcplondon.ac.uk.

Physicians in a foreign land

Editor – We were interested and encouraged by Paul Streets' editorial on patient empowerment and the changing role of the physician (*Clin Med* January/February 2003, pp 7–8). He reports that diabetes is an area where innovative approaches to patient involvement in care are taking place. He goes on to urge examination of skillmix issues and tackling 'professional demarcation under the guise of protecting patients'. According to Streets, we should go back to the drawing board and 'radically reappraise who does what'. He states that specialist patient groups like Diabetes UK will work to ensure that change is achieved 'without compromising quality'.

Whilst wholeheartedly supporting the general direction of Paul Streets' polemic, we would urge a degree of caution before embarking on a wholesale dismantling of existing specialist diabetes services for the sake of role diversification, devolved care and patient empowerment.

Diabetes is a good example of a medical specialty that generally delivers high quality care in a structured environment. However, we know that there are not enough specialists and that many clinics are poorly supported.[1] We also know that some patients find it difficult to access hospital-based services. Nevertheless, we do not believe that the answer to the problem is a headlong rush into a primary care based diabetes service using untested innovations such as GP specialists, nurse consultants and prescribing pharmacists.

We would remind Paul Streets that a consultant diabetologist has to navigate a highly structured 5-year specialist-training programme leading to the award of a Certificate of Completion of Specialist Training (CCST). Most diabetologists also practise specialist endocrinology and make a large contribution to acute general medicine. Diabetologists are committed to delivering high quality diabetes care and, because most are long serving, they are able to provide long-term continuity of specialist care for their patients.

The Association of British Clinical Diabetologists (ABCD) strongly supports the development of specialist skills by other professionals properly trained to deliver specialist diabetes care providing that there is no loss of quality and that there is a clear understanding of respective roles and responsibilities. For example, ABCD is working closely with the Royal College of General Practitioners to develop a training and competency framework for the General Practitioner with a Special Interest in diabetes.

However, a recent survey by Diabetes UK[2] has shown substantial deficiencies in GP diabetes care, and Pierce[3] has shown that GP exposure to diabetes CME is seriously inadequate in many areas. Thus, it seems clear that it is going to take several years to develop adequate specialist diabetes skills in primary care. Furthermore, we believe that this will only happen if there is strong clinical and educational support from local specialist diabetes consultants. However, many specialist diabetes services are seriously under-resourced and

are already under considerable pressure. Apart from the need to give additional support to primary care, there is likely to be an increase in workload resulting from improvement in primary care of diabetes because this generally causes an increase in referrals to secondary care.[4] The recently published Diabetes National Service Framework is also likely to generate more referrals as a result of the increased pursuit of quality targets.

Thus, ABCD believes that to achieve Streets' proposed adjustment of roles and skillmix will require a substantial and rapid increase in consultant numbers. This will depend on an immediate increase in the number of specialist trainees. Whilst ABCD welcomes this year's increase in the number of National Training Numbers allocated to Endocrinology and diabetes, we are disappointed that most are unfunded, which will lead to difficulties in placing trainees in many of the best training centres. Moreover, even if all the posts are successfully established, the number is too small and the training programme too long to make a significant difference in the short term, if ever.

Thus, it seems to us that it is most unlikely that there will be enough consultants to support these primary care initiatives and that there is a real risk of two standards of practice developing which could adversely affect patient care. We would urge caution and wish to emphasise the importance of the preservation (and strengthening) of existing specialist services because we believe that this is crucial if we are to avoid the evolution of lower quality care for many of our diabetic patients.

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Diagnosing HIV infection

Editor – I enjoyed reading Susan Forster's well-written article in the CME Section on Genitourinary Medicine (*Clin Med* May/June 2003, pp 203–5). However, I feel that her suggestion to consider HIV infection in the context of a diagnosis of lymphoma needs further clarification.

The incidence of non-Hodgkin's lymphoma (NHL) is indeed 60 to 200 times higher in patients with AIDS.[1] However, such an association is restricted specifically to high- and intermediate-grade histological types, rather than to NHL as a whole. Such patients are more likely to exhibit extra-nodal involvement.[2] Furthermore, there are particular lymphomas which show a striking correlation with HIV/AIDS, such as primary cerebral lymphoma (1,000-fold increase compared with background population rate[3]), Burkitt's lymphoma, Burkitt-like lymphoma and large B-cell lymphomas.[4] There is also increasing recognition of unusual types, such as the human herpes virus 8 (HHV-8) associated primary effusion lymphoma.[4]

To a lesser extent (up to eight-fold relative risk) there is an association between HIV infection and Hodgkin's disease.[4]

Common to all forms of HIV-associated lymphoproliferation is a comparatively worse prognosis than for immunocompetent patients.[2,4] This relates not only to the fact that the lymphoma is more likely to be at an advanced stage at diagnosis,[4] but also that such tumours are often a late manifestation of HIV infection. Given the survival benefit of highly active antiretroviral therapy (HAART) to HIV infected patients, it is likely that the incidence of AIDS-related lymphoma will increase with time. However, what seems less certain presently is the impact HAART will have on survival of AIDS patients with lymphoid malignancy.[2]

In summary, whilst I endorse Dr Forster's views on heightened awareness amongst physicians of HIV-related illnesses, I feel that HIV screening can only be justified in patients with lymphoma whose disease fits into the above histological and clinical categories.

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In response

I absolutely agree that it is essential to perform HIV testing in patients who have the form of lymphoma which Dr Murrin describes. Many physicians would also at least consider an HIV test in any malignancy where the presence of HIV infection would influence the management or prognosis of the malignancy, or where a less strong association with HIV infection has been suggested, eg anal cancer, cervical cancer, various skin and testicular tumours, myeloma and adenocarcinoma of the lung. My impression is that as as our patients (fortunately) live longer as a result of antiretroviral treatment, this will become increasingly important. There are very few patients for whom a negative HIV test will do them harm, whereas missing a diagnosis of HIV infection may have devastating consequences.

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