

Clinical Medicine November/December 2004 pp 591–2.

Dr Holt includes the statement taken from Tallis's book that 'there are now many more medical schools places, but there has also been a sharp drop in applicants to the extent that in a year or so nearly all who apply will be accepted.' In fact, this is far from the case, for entry in 2005, applications to study medicine actually rose by nearly 20%, and for entry in 2004, applications rose by nearly 30% from the previous year's figures. This means that there are now more than 19,000 applications for 8,000 places, so it is very unlikely that nearly all who apply will be accepted. The Council of Heads of Medical Schools is working with colleagues to consider how different ways of assessing these candidates can be developed.

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Symptoms and perceptions of disease

Editor – I was fascinated by the very clear exposition of the problem symptoms and perception of disease by Dr Donaghy (*Clin Med* November/December 2004, pp 541–4), but perhaps one aspect of this was under-emphasised. Deconditioning, the opposite of training, may also contribute to the imbalance between symptoms and organ impairment.

As Dr Donaghy points out, there are many reasons for the disproportionate perception of the severity of disease besides the obvious frank malingering including 'compensationitis', and what used to be called 'poor moral fibre'. A patient attending for the first time with back pain might be resentful at a seeming lack of concern on the doctor's part. Another doctor might take the easy way out and unconsciously try to please by ascribing breathlessness to a totally unwarranted diagnosis of emphysema which acquires immortality in the notes and can never be undiagnosed in the patient's mind.

Often, new symptoms have a disproportionate impact simply because they are new. Each of these may set up a vicious circle of decreased activity and reactive

depression on the one hand, and decreased fitness and a real increase in symptoms on the other. The deconditioning then becomes independent of the precipitating factor and so it will persist even if the latter is removed. The implications of this to clinical practice are that the initial management is critical, and to medico-legal practice that even where the acute 'compensationitis' was malingering, the chronic phase might reflect genuine symptoms.

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Team working

Editor – In the November/December 2004 issue Carol Black and Alan Craft see good decision-making in teams that promotes alignment of values and behaviour, forms alliances with members of other teams, and good communication within and between teams as requiring, 'strong leadership' (*Clin Med* November/December 2004, pp 527–33). I agree with this conclusion about the appropriateness of the leadership model in team working but the reality is far from being as precise as the article implies.

In clinical teams, it is possible to identify four basic models of decision-making – all of them previously identified in the NHS. These are the leadership model, the democratic model, the consensus model and full or partial anarchy. The consensus model is found where there is no urgency for a clinical decision and where one key decision will have a long-term effect on the patient. Mental health is one area of the NHS where this model occurs most frequently. By contrast the democratic model occurs where there is an urgent need to take a decision to treat and where non-doctors do not accept a leadership model. Crisis teams dealing with vagrants in community settings contain some doctors who have admitted to allowing themselves to be outvoted in respect of urgent clinical decisions needed because the patient is not likely to reappear (as opposed to being genuinely clinically persuaded about the greater appropriateness of the choice).

The most common alternative to the leadership model is whole or partial anarchy. This defines a situation where the team fails to function as a group and where

each individual clinician insists upon taking their own decision about what they should do with the patient irrespective of the views of other members of the team. Partial anarchy refers to a more common position in which a leadership model operates for a tight central core of decision-making with wider decisions relating to the patient being taken individually.

Anarchy can occur when one professional group is seeking what the team member feels to be greater independence from the team leader, usually the doctor. This is when decisions to behave independently are taken outside the team, as opposed to team discussions where the 'leader' makes major concessions on the clinical decisions taken in order to keep the team together.

In the last 20 years, the practice in clinical teams has drifted away from a firm and unchallenged acceptance of the leadership model in a way that can be clearly measured on a spectrum. The more urgent and acute the condition of the patient, the stronger the leadership model within a formal NHS setting. The more chronic the patient's condition and the fewer clinical interventions needed, the more likely it is for the leadership model to erode into a form a bargaining, the best negotiator often having greater influence than sapiential authority might imply. This erosion is worrying and it is good that the College is addressing these fundamental issues. It is because the patient is not best served by an arrogant team leader who does not take seriously the contribution of other team members, that this is such an intractable issue. The ideal is a team leader who understands the group dynamics and can ensure that they are used to the patient's best interest.

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Fluid, electrolytes and nutrition

Editor – In reading Simon Allison's informative and engaging article 'Fluid, electrolytes and nutrition' (*Clin Med* November/December 2004 pp 573–8), my attention kept on being drawn back to the opening paragraph.

I am sure that Professor Allison meant to