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 sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Where is the sharp end and how did we get here?

Editor – The paper by Almond (*Clin Med* April 2007 pp 105–8) does not mention two challenges that acute medicine has to overcome: one organisational, and the other clinical and intellectual.

The organisational one is that, though the Royal College of Physicians sees the role of acute medicine as one of improving the management of acutely sick patients, in practice these patients represent a small minority of today's takes. Management therefore view the physicians' role as being to decide who needs to stay in hospital and to expedite the discharge of the rest.

The clinical and intellectual challenge is the tendency, in my experience, for medicine on the acute medicine unit to be directed more towards 'excluding' or managing a select few high-profile conditions, such as acute coronary syndrome or deep vein thrombosis, rather than actually establishing a diagnosis. There is therefore a tendency for patients to be discharged with the knowledge of what is not the matter, but not what actually is. While sometimes this may not cause any great harm, it is hardly good for our intellects or for the training of junior physicians. The best method of ensuring speedy and safe discharge is accurate diagnosis – a sentiment with which I hope all acute physicians would agree.

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In response

I agree with Dr Dunstan that trusts value the role of acute physicians in expediting safe and appropriate discharge. I also see this as important, both clinically and moreover as a justification for the employment of acute physicians and development of the service. The willingness of trusts and strategic health authorities to support acute medicine has to be in part related to this and in today's climate it is crucial to be financially and organisationally appealing to trusts. My suspicion is that acute medicine will remain a robust specialty in this respect while I fear others maybe significantly compromised. I do wholeheartedly agree with Dr Dunstan that it is insufficient simply to exclude a diagnosis. While there are clearly still instances of this practice, my impression is that the breadth of experience and skills of many of the acute medicine appointees will ensure that rational diagnoses and treatment plans are generated for every patient, even those on care pathways. To my mind, the real challenge here comes with nurse-led, protocol-driven pathways where the capacity to generate alternative diagnoses maybe suboptimal. Design of these pathways must be mindful of this and ensure that non-medical staff have ready access to competent medical advice for the complex cases.

SOLOMON ALMOND
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Medicine at the sharp end

Editor – Dr Almond's article (*Clin Med* April 2007 pp 105–8) was timely and thought provoking. Being one of the first specialist registrars (SpRs) in acute medicine in the West Midlands Deanery, I noticed the difference in attitude towards the specialty. I still remember the scepticism of my colleagues and seniors towards acute medicine as a subspecialty in the initial years. This has dramatically changed in the past few years and acute medicine is turning into a 'coveted' subspecialty, though I do agree that we still have a long way to go and cannot rest on our laurels. Dr Solomon rightly pointed out that the Society for Acute Medicine UK and the Royal College of Physicians have played a major role in raising the specialty's profile.

One of the charges against acute physicians is that they are failed physicians ie that they failed to make an impact in their own specialty. I addressed this issue in my article on choosing acute medicine as a career for junior doctors.[1] I fully agree with Dr Solomon that a majority of physicians who crossed over from other specialties into acute medicine made a 'conscious and proactive decision to do so'. I have been fortunate to have worked with some of the best 'crossed over' acute physicians.

Acute medicine shares a major interface with accident and emergency (A&E) and critical care. While the interface between A&E and acute medicine has developed considerably in the past few years, the interface between acute medicine and critical care needs to be developed further. This is an area that has a potential to develop exponentially, particularly with regard to medical high dependency units. It has been estimated that one level 2 bed is needed for every 10–15 medical admissions.[2] I envisage future acute physicians playing a major role in developing this interface.

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References

1 Chandran S. Acute Medicine. *BMJ Career Focus* 2006;333:177–8.
2 Royal College of Physicians. *The interface between acute general medicine and ITU.* Report of a Working Party. London: RCP, 2002.

Career lifetime advances and key developments: diabetes

While we share Tesfaye's view that treatment of painful diabetic neuropathy is challenging (*Clin Med* April 2007 pp 109–18) we doubt that there is a reliable evidence base supporting the use of gabapentin or new medications (pregabalin, duloxetine) over tricyclic compounds. The way gabapentin has been promoted in the management of neuropathy and other disorders has been the subject of a review based on industry internal documents that raises scientific and moral concern.[1] Approval of