letters
TO THE EDITOR

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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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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

pregabalin by the European Agency for the Evaluation of Medicinal Products was based on 12 trials (eight unpublished), which showed that the drug was superior to placebo but inferior – in the only comparative trial available – to amitryptiline.[2] The approval of duloxetine relies on two short-term (12-week) trials with placebo as a comparator, without any formal comparison with other drugs used for the treatment of neuropathic pain.[3] While the supposed superior efficacy and tolerability of these drugs over tricyclics remains to be proven, there is no doubt about their superior cost to the NHS:[4] the incremental annual cost of the new drugs over amitriptyline (comparisons at maximum daily dosage) approaches 13 for duloxetine, 15 for pregabalin and 40 for gabapentin (although the cost of gabapentin is expected to be much reduced as soon as the generic formulation becomes available). We believe that for this money, the taxpayer, the doctor and, most importantly, the patient are surely entitled to a stronger evidence base.

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2 Pregabalin. Prescrire International 2005;14:203.
3 UK Medicine Information NHS. *Duloxetine for diabetic neuropathic pain.* August 2005. www.ukmi.nhs.uk/NewMaterial/html/docs/Duloxetine0805.pdf
4 Is there a place for duloxetine? *Drugs Ther Bull* 2007;45:29–32.

Neurological problems on the intensive care unit

Editor – Once again a learned article on coma (*Clin Med* April 2007 pp 148–53) fails to include cerebral malaria as a possible, and eminently treatable, cause. Several deaths from this occur annually in Britain because no adequate travel history has been elicited and the possibility of the diagnosis has not been considered. Clinical signs may include meningism, convulsions, paralysis of conjugate gaze, extensor plantar responses and retinal haemorrhages.

GEORGE COWAN
Former Medical Director
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Where are you from?

Editor – I read your editorial with interest (*Clin Med* April 2007 pp 101–2). The account of a conversation with an Iraqi doctor described a healthcare system that was flourishing under Saddam Hussein until it was ruined in the aftermath of the invasion of 2003 and the subsequent lawlessness, kidnapping and murders.

I have had the good fortune to be in Baghdad twice in recent years. The first occasion was immediately after the regime change, when I spent an extended period working on public health and reconstruction with the new Iraqi Ministry of Health, which brought me into daily contact with a wide range of doctors, nurses and health officials. The second visit was for a briefer period in 2005 to discuss assistance to Iraq in updating clinical skills, which again involved frequent contact with clinicians. On neither occasion did I meet any Iraqis who shared the view put forward through the editorial that all had been well with health services before 2003.

On the contrary, I heard repeatedly of the systematic rundown of health services under Saddam and its devastating effects. Spending on health in 2001 was one-tenth of the level 10 years earlier, and I saw plenty of evidence of long-term decline with my own eyes in May 2003. I heard numerous accounts of the deliberate denial of vital drugs and equipment to sections of the population that had angered Saddam, and the memories of the distress of those who told me of the entirely preventable pain and suffering that resulted remain with me. From the time of the Iran–Iraq War, the borders were closed to most Iraqis, and accessing information from the outside world was forbidden. As a result, clinical skills stagnated as textbooks aged and could not be replaced, conference attendance became impossible, and training became outdated. Iraqi doctors were desperate to update their knowledge and skills – the reason for the work that we have been able to initiate and that occasioned my second visit. I heard that many of the brightest Iraqis did indeed continue to enter medical training – some things are difficult to change, it seems – but on qualification the best were compulsorily drafted into the Army medical services. Another strongly persistent memory is of being taken by a young ex-Republican Guard doctor to the prison camp he had been obliged to work in, with its gruesome torture chamber and large mass graves.

As a result of many conversations in Iraq as well as my own observation, I am sure that health services in Iraq were indeed well run and extremely capable – but only before Saddam came to power. By the time he was removed, they were in a very poor state indeed, even when not perverted as another cynical instrument of state control. The great majority of individual clinicians certainly did the best they could under desperately difficult circumstances, but the idea that there was a well-managed health system for anything but the favoured minority is unsustainable.

Of course nobody would deny that the terrorism and kidnapping since 2003 have disastrously set back attempts to improve life, health and well-being for Iraqis, as well as causing widespread human misery for those affected directly and indirectly. But to suggest that life was good under Saddam, or that services were well managed and effective, at best runs counter to the evidence; at worst, it risks offence to the great majority of Iraqis, many of them no longer able to speak for themselves.

BILL KIRKUP
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Personal viewpoint on revalidation

Recertification for specialists in the UK will be introduced over the next couple of years and seems likely to involve knowledge-based assessments and direct observation of procedural skills (DOPS). Most consultant physicians will be daunted by the