plans for her further care and return home.

It is not what we write but what we do that makes the difference to how we care for the patient. More informative notes are the product of informed writers, and even the best physicians cannot distil essence from barren mud.

ROBERT A COCKS
Director of the Accident and Emergency Medicine Academic Unit
Prince of Wales Hospital, Hong Kong

Views on CME

Editor—Professor Kerr has made the trenchant observation that the objections against ‘counting’ reading the literature as Brownie points can be levelled against most of the other CME activities. This questions the whole validity of the scheme. There are other reasons for scepticism. Is there really any evidence of under-performance by physicians—or at least deficits that have been shown to be remediable? None of the techniques of evidence-based medicine have been applied to this experiment. We have not defined what is wrong—the disease—or even identified outcomes to measure the efficacy of the supposed remedy. Attendance at officially approved rituals appears to be deemed a satisfactory surrogate for improvement in practice. How much is it all costing the Royal Colleges—never mind the tax-payer, who might prefer external assessment? The creaking expensive machinery of the audit industry should have provided warning enough that rotten apples are not made whole by inspection. In my experience, rotten apples are indeed rare, although usually very skilled at evading criticism and correction. The Colleges should trust their own screening methods to prevent accreditation of unsuitable doctors. They should also trust those who have passed the educational hurdles to maintain self-education and self-criticism—the only really effective guarantee of professional competence. The introduction of compulsory CME is not only an insult to mature physicians, but also an implicit admission that the Colleges have not been successful in training doctors for independent practice. Worst of all, however, is the adoption of an uncusted experiment whose efficacy can never be properly assessed. My heart goes out to the two heroes who have refused to participate in this farrago. Persecuted they undoubtedly will be, but they will earn the martyr’s crown.

G H HALL
Exeter

Epilepsy review

Editor—I refer to Epilepsy, edited by Simon Shorvon, Gregory Cascino and myself, published by Chapman and Hall, and reviewed by Dr Pamela Crawford on page 186 of the March/April 1996 issue of the Journal.

I know that it is not an easy task to review a large multi-author textbook, but I do believe that reviewers have a responsibility to editors, chapter authors, and above all to potential readers of books to ensure that any criticisms are well founded.

Much of Dr Crawford’s review is taken up with criticising a single section on epilepsy in pregnancy (Chapter 17a), but it does not appear that she has read even this section with care. She states that it does not mention the need for preconception counselling, but there is a whole Table (Table 17a. 2 on page 550) which reproduces fully the guidelines for preconceptual advice which were generated at an International Symposium on Pregnancy, Teratogenesis and Genetics in Epilepsy. With regard to her other specific criticism, the role of alphafetoprotein and ultrasound monitoring in detecting fatal abnormality is addressed on page 550.

Dr Crawford states that there is no mention of the problems a woman with epilepsy might encounter in trying to bring up a child with epilepsy. It seemed inappropriate to include such a section in a chapter on pregnancy, but there is a major section about the parents’ contribution to helping a child with epilepsy, and a section on schooling and emotional and psychological problems of children with epilepsy in Dr Edward Brett’s chapter. In addition, there is a whole chapter on counselling in epilepsy, which considers in particular the relationship between parents and children with epilepsy.

Dr Crawford also criticises the book for there being ‘no discussion of the possible future role in pregnancy of the two new antiepileptic drugs (lamotrigine and gabapentin). There is no evidence as yet to justify the use of either drug in pregnancy, and indeed the standard data sheet on lamotrigine states ‘Lamotrigine is a weak inhibitor of dihydrofollate reductase. There is a theoretical risk of human fetal malformations when the mother is treated with a folate inhibitor during pregnancy.’ The role of gabapentin in pregnancy is considered on page 191 in the book on which it is clearly stated that its safety in pregnancy has not been established, a point again confirmed in the manufacturer’s data sheet.

It is difficult to write complaining about a book review, because this may just seem like sour grapes. However, I believe that reviews should also be open to criticism as are papers submitted for publication.

ANTHONY HOPKINS
Consultant Neurologist
St Bartholomew’s Hospital, London

Consultant Physician of the Week:
a solution to the bed crisis

Editor—The article by Richard Worth and Giles Youngs (May/June 1996, pages 211–2) is a useful paper to include in a copy of your
journal which also considers Continuing Medical Education.

A basic rule of management is that when a change for improvement is proposed, a base measurement is chosen against which the change can be compared. A basic rule of study design is that all variables should be controlled, other than the one being tested.

How can Worth and Youngs conclude that their system of ‘Consultant Physician of the Week’ is responsible for their happiness, rather than other changes?

Any of the following changes, which also occurred, would make me a happier consultant physician:

- additional £720,000 given to the Medical Directorate;
- gain a ward from Surgical Directorate (no mention of happiness of surgeons);
- integration of general medicine and medicine for the elderly;
- additional bed coordinator, nurse practitioner, phlebotomists, electrocardiography technician and a 24-hour service for case note retrieval.

I exclude ward-based, rather than patient-centred consultants—this might save time and walking but damage patient-doctor relations.

TONY MITCHELL
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The North Middlesex Hospital

Elderly patients excluded from resuscitation discussion

Editor—I read with interest the article about when elderly patients can be excluded from discussing resuscitation (March/April 1996, pages 133–5). I note that the authors conclude that the majority of elderly patients can be excluded from discussing resuscitation either because DNR decisions are made on the basis of futility or because they are incompetent to participate in these discussions. I would concur with this as there is no need to provoke unnecessary concern in a vulnerable elderly patient if treatment is deemed to be futile by the clinician. Despite this we have found that elderly patients welcome discussion on CPR and are not upset by it and indeed the majority would accept the advice of their doctor on a CPR decision [1].

There will, however, be the small minority of patients whom it is appropriate to involve in a CPR policy decision. This situation demands a compassionate clinician with good communication skills. However, many senior clinicians lack the communication skills required for this and few have ever been trained in discussing such emotionally charged subjects with patients. Fortunately, medical schools are now seeing the error of their ways and have introduced communication/role play tutorials. It took me some time and several ‘clumsy’ approaches on discussing CPR with patients to realise that the best approach is to say to the patient ‘Mrs Brown, did you know that this hospital has a resuscitation policy for patients? I wonder what you think about this and if you have any questions to ask me?’ This ‘open ended’ question approach opens the discussion with the patient. Some hospitals publish in their patient information booklets that they have a CPR policy and if this is so, it can be referred to by the clinician to open the discussion with the patient.

Although it is inappropriate to discuss CPR with most elderly patients, for those whom it is necessary to involve in discussions, it is essential that the doctor possesses adequate communication skills. This topic should be included in both undergraduate and postgraduate training programmes.

Reference
1 Morgan R, King D, Prajapati C, Rowe J. Views of elderly patients and their relatives on cardiopulmonary resuscitation. Br Med J 1994;308:1677–8.

DEBRA KING
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London Open House ‘96

On Saturday 14 September 1996 the College is taking part in Open House ‘96. This forms part of European Heritage Days when 30 European countries open up buildings of architectural interest for the public to visit. The aim of these Days is ‘to bring people closer to their cultural heritage by throwing open the doors to the country’s notable buildings.’

The College, which has recently been recommended for a grade II* listing, will be open to the public from 10.00am until 4.00pm, with exhibitions, a short film about the College and the chance to view the new extension (which comprises a lecture theatre, reception room and meeting room). Members of staff will be on hand to answer questions about the building and refreshments will be available.

Please contact Mrs Nicky Higgins on 0171 935 1174 x260 if you require any further information.