**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: Bettina.Klar@rcplondon.ac.uk.

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**GiM and specialty medicine**

Editor – I was rather surprised to see the term ‘acopia’ towards the end of the article by Rhodes et al (July/August 1999, pp 341–7).

Butterworths Medical Dictionary defines acopia as ‘difficulty in making a copy on paper from printed or written text (GK a not; L copia transcript)’. Did the authors really mean to use the term in this context? I suspect that they did not and one is tempted to invoke Humpty Dumpty: ‘When I use a word ... it means just what I choose it to mean – neither more, nor less’.

Would the authors care to explain their use of the term to the readers of the Journal?

Reference

1 Carroll L. *Through the Looking Glass.* Macmillan Childrens Books, 1998.

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**A J KRENTZ Consultant Physician, Southampton General Hospital**

Editor – As a now retired physician and defunct postgraduate dean, may I offer a view on the generalist versus specialist ‘issue’ (July/August 1999, pp 341–7)? As a physician in the general medicine directorate, headed by Professor Jonathan Rhodes, I supported his efforts to ensure the best care for patients; but as postgraduate dean was concerned for the effects of triage on training of junior doctors and the continuing professional development of consultants.

As educational supervisor for a pre-registration house officer, it was rare for both of us to see patients from the day of admission to discharge. Continuity of care, under the supervision of a consultant or SHO/registrar is an important part of the pedagogy for general clinical training. That is now lost, and the misfortune is compounded by the partial shift working patterns demanded by Task Forces.

Similar concern pertains to general professional training of SHOs, who count two years as part of the five needed for certification in general (internal) medicine. Rotation between specialties may partly atone for gaps in experience, but in the absence of competence-based assessment, which MRCP(UK) only in some measure fulfils, new recruits to higher training are unlikely to cover the College recommended core curricula.

Training of the specialist registrar in GiM also causes some disquiet, particularly if large gaps are identified at a penultimate year assessment (PYA).

*Hospital doctors: training for the future* recommended introduction of specialist curricula, competence-based assessment and structured training programmes. Rotational training schemes do not provide structured training in GiM because, as Professor Rhodes and his colleagues recognise, there is blurring of the distinction between generalist and specialist components. I hope that the JCHMT will make proposals for change and structuring of programmes based on cumulative experience of PYAs.

No less important is the continuing professional development of consultants who take part in general medical take. Few consultants are able to follow a patient from the admission ward to discharge. A clinical decision made on the basis of a snapshot is more likely to be well-grounded if he who makes it has had recent opportunity for continuing care of patients with that illness. Present arrangements for continuing medical education are less likely to help the physician faced with a difficult decision than the learning that comes from reflection motivated by continuing care.

Continuity of care by a physician and those for whose training he is responsible, is under threat. Whilst it is important that the ‘right’ specialist sees the patient, the education of house officers and registrars plus the personal development of consultants should not be neglected. The competence and performance of the general medical team ‘on take’ is just as important to the patient.

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**T J BAYLEY Former Consultant Physician, Royal Liverpool University Hospitals NHS Trust and Postgraduate Dean, University of Liverpool and NHSE North West (West)**

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**Lowering cholesterol**

We question the validity of some of Professor Oliver's arguments for a conservative approach towards lowering plasma cholesterol in the very elderly (May/June 1999, pp252–3).

He believes that in this population a raised cholesterol is of limited consequence as mortality is high from cancer and accidents, while morbidity is dominated by senility, Alzheimer's disease and Parkinson's disease; he also believes it would be unethical to mount a trial in the very elderly to establish whether lipid lowering therapy is beneficial.

Controlled trials involving men in their seventies with coronary artery disease (CHD) have shown benefits from lowering cholesterol1–3. Specific mention could also have been made of the CARE study4 in which pravastatin was used to lower cholesterol in patients with a history of myocardial infarction aged between 21 and 75 years. The results showed a significant reduction in cardiac events, the need for coronary bypass grafting and strokes. There was a five year follow-up and the benefit of treatment was no less in the older than in younger patients. The apparent lack of relationship between plasma cholesterol and CHD in the elderly in epidemiological studies could be explained by the co-morbidity that can occur in the aged.

In terms of primary prevention there is a lack of evidence regarding treating the very elderly asymptomatic patient who has hypercholesterolaemia. However, a concern with evidence-based medicine is that the absence of evidence for treatment can be interpreted as evidence for