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: Thomas.Allum@rcplondon.ac.uk.

Careers in academic medicine

Editor – I agree with Professor Shaw (September/October 1999, pp470–3) that a clinical academic risks being looked down upon by both full-time clinicians and full-time scientists. This may be exacerbated by lack of confidence related to spending time at home looking after young children. However, research often fits in well with family life, as, unlike clinical commitments, it can usually be postponed if necessary.

I have two further suggestions. Be assertive. You can't do everything – clinical, research, teaching and being a parent. Practise saying ‘no’ in the mirror. Secondly, to compensate for the relatively low pay, job insecurity and long hours, try to find a rich and supportive partner!

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GIM and specialty medicine

Editor – We agree with Rhodes et al (July/August 1999, pp341–7) that acutely-admitted medical patients probably fare better if managed by a specialist relevant to their principal problem, rather than by a generalist. We are, therefore, astonished that the General (Internal) Medicine Committee of the Royal College of Physicians of London discussion document did not mention the possibility of patients being admitted under neurological care. Indeed, our specialty is apparently not even considered to be allied to general medicine.

We recognise that in the past neurology has been over-centralised, separatist and even elitist, but times have changed and there are an increasing number of neurological centres that accept and manage acute neurological patients. There are also an increasing number of neurologists in district general hospitals (DGHs) who can see and advise on neurological patients within 24–48 hours. We wish we could do more, and we shall do more once we have a sufficient number of consultant posts to deal not only with the acute neurology, but also with neurology outpatient (currently the latter may have to wait more than six months to be seen in many parts of the country) and with chronic neurological disability.

District general and teaching hospitals are only slowly expanding their neurological sessions. If all neurological ward referrals are to be seen promptly, preferably within 24 hours, there needs to be a considerable expansion in the number of consultant neurologists. Before adopting the proposals for a DGH triage system set out in Table 3, which completely excludes neurologists, the working party should acknowledge the need for two consultant neurologists for every 200,000 of the population, before appointing more consultants in cardiology, diabetes etc.

The document reveals an extraordinary ignorance of modern neurology and sadly illustrates the long-standing scotoma that the General/Internal Medicine Committee of the RCP has for our specialty. Importantly, patient organisations are more on the ball with their desire for neurological patients to be seen by neurologists. They would take a dim view of patients with epilepsy, for example, being triaged to clinical pharmacologists, and those with headache taking their chance with a gastroenterologist. The concept that clinical pharmacologists, and not neurologists, should triage epilepsy is all the more ridiculous when one realises that there are only 64 consultant clinical pharmacologists in England and Wales, but 281 neurologists (1998 Royal College census). Finally, most hospitals do not have a clinical consultant in infectious diseases, even though the paper suggests that meningitis and encephalitis should come under their care. These illnesses must be within the neurological remit.

The discussion document must be amended to reflect modern medical practice and what patients want. We hope that the new organisational structure in the College will ensure that such unhelpful proposals regarding the management of neurological patients never reach the public arena again.

C P WARLOW, President-Elect R NEWSOM-DAVIS, President P R D HUMPHREY, Honorary Secretary D H MILLER, Honorary Assistant Secretary D L STEVENS, Honorary Treasurer C KENNARD, Chairman RCP Committee on Neurology Association of British Neurologists, London

In response

Editor – We welcome the support given by Professor Warlow and colleagues for our view that acutely admitted medical patients will fare better if managed by a relevant specialty team. Our proposed system of triage requires that patients be allocated to the relevant specialty team within 24 hours of admission and that team be able to provide 24-hour care throughout the week. We would all welcome enthusiastically the presence of neurological teams operating such a service on site and willing to receive patients triaged directly from the acute medical take. Appropriate patients for triage could then undoubtedly include patients with epilepsy or meningitis. It would also be very helpful to have day-to-day input into the management of patients with cerebrovascular accident.

The College's own figures (shown in Table 2 of our paper) suggest that only 5% of neurologists are involved in acute general medicine, and the centralisation of neurological services in many regions, including Mersey, means that a radical increase and alteration in distribution of neurologists would be required to produce for each district general hospital a team that could provide continuity of care for appropriately triaged patients. This is nevertheless a laudable aim and one that we should all try to encourage, given such strong support from the
Association of British Neurologists. A system of rapid review of ward referrals without responsibility for care would, however, still leave us having to choose the most appropriate non-neurological team for triage of these patients.

It should be pointed out that the appendix to our paper sets out the triage as run in the Royal Liverpool University Hospital and is meant simply to show how the system has been established given one hospital's specialty mix of consultants. It is not intended to be a prescriptive model.

We think many of us are probably guilty of underestimating the enthusiasm of neurologists for becoming fully involved in the management of appropriately triaged acute medical admissions and we are sure the sentiments outlined by Professor Warlow and colleagues will be warmly received by all physicians involved in management of the acute medical take.

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Appropriate transfer of patients from the medical admissions unit (MAU) depends on bed availability. Unfortunately, many hospitals (including our own) have such a high bed occupancy for general medicine that patients have to be sent to wherever a bed happens to be available, which may not even be on a medical ward. This means that a patient may not only be looked after by an inappropriate consultant but also by different consultants on different admissions. ‘Consultant hopping’ leads to complaints from patients, relatives and general practitioners.

It is suggested in the article that patients who have been inappropriately transferred from the MAU can be transferred to the appropriate ward subsequently, but this means that a bed will no longer be available for another patient waiting on MAU. Transferring patients also leads to complaints.

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Physicians as educators

Editor – Dorman's editorial on the role of the physician educator (September/October 1999, pp 414-6) recognises the importance of workplace learning. The General Medical Council acknowledges that senior house officers (SHOs) have a service commitment to fulfil as well as educational needs, and recommend the use of service-based learning as an educational tool The teaching ward round is an ideal opportunity to combine clinical service and education of junior staff. Furthermore, teaching on ward rounds fosters good relations between junior and senior staff, and contributes significantly to SHOs' job satisfaction.

If time is to be invested in service-based learning, it is important to explore the views of the learners. As part of an Effective Teaching Skills course at Birmingham Heartlands and Solihull Trust, we undertook a survey of the attitudes of SHOs to learning on ward rounds. We found that two thirds of SHOs were taught on ward rounds by a registrar or consultant at least once a week. Of these, one third received teaching daily. Of ten SHOs who received consultant teaching at least once per week, eight regarded it as excellent or good and the other two as reasonable.

Key attributes of a good teacher identified by the SHOs were: being approachable and receptive to questions, asking stimulating questions, and providing feedback on performance. A proportion of respondents emphasised that they did not wish to be taught by humiliation. The most popular teaching was patient focused, built on and tested existing knowledge, linked theory and evidence to practice, and discussed the rationale behind management plans. The sharing of consultants' own learning experiences was well received.

SHOs were aware of the service component of ward rounds and it was not felt necessary, or indeed desirable, to teach with every patient. Instead, selecting commonly encountered clinical problems or interesting cases, and debriefing over coffee at the end of the round, was seen as a more efficient use of time.

Despite increasing workloads, consultants can be confident that time and effort spent in making ward rounds a good learning environment is greatly appreciated by trainees, increases job satisfaction and leads to better patient care.

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3. Perkins G, Rayner H. Teaching and learning on ward rounds – a vital part of medical training. In: Morton A, Rayner H, Wallis P (eds). Good practice in clinical teaching. A collection of case studies from Birmingham Heartlands and Solihull NHS Trust (Teaching). Birmingham, 1999.

How to intervene against smoking

Editor – It is regrettable that McEwen and West's article (November/December 1999, pp513–5) failed to address the issue of smoking cessation in hospital