Letters to the Editor

Junior doctors training in emergency medical procedures

Editor—Like Davis and Roberts (September/October, pages 432–4) we recently conducted a questionnaire survey of junior doctors in training in seven hospitals in the West Midlands region. The survey focused on experience of, instruction in and teaching of two emergency medical procedures—chest drain insertion and temporary transvenous pacing—both of which the respondents would be expected to perform in the course of their on-call duties. In short, we wished to ascertain whether 'see one, do one, teach one' was still a reality in modern postgraduate education.

The 53 respondents to the questionnaire (83%) included 33 senior house officers, 18 registrars and two senior registrars, all of whom were on their hospital rota as duty receiving medical officer. The respondents mean age was 28.3 ± 2.7 years; they had been qualified for 4.6 ± 2.4 years and worked a mean of 71 ± 9 hours per week (Table 1). The number of times both procedures were performed was not particularly high, tending to limit the likelihood of gaining technical proficiency. Most of the study group, having been trained in these procedures by relatively junior staff, then began to perfom both procedures fairly quickly, after which few would be likely to receive further instruction. Most respondents had themselves instructed others in the index procedures.

These facts suggest that there is the potential for poor technique to creep into the 'learning chain'. To prevent this danger being realised we would suggest that a more formalised and structured approach to training in practical procedures should be adopted. This might involve the appointment of local training officers to ensure that adequate arrangements are made for the acquisition of such skills during general professional training. Such a system has been adopted for resuscitation training with considerable success but is surely also justified for other hazardous medical procedures. The training officer may need to do no more than periodically survey staff, identify those that feel unsure and identify individuals in the unit who would be best placed to offer the appropriate training. We believe that these measures may become particularly important with the progressive reduction in 'on-call' hours.

Table 1. Data from 53 respondents concerning the performance, instruction in and teaching of the two index procedures

	Chest drain insertion	Temporary transvenous pacing
Number in last 6 months	3.4 ± 2.4	2.6 ± 3.7
Number performed supervised prior to independent practice	1.6 ± 0.8	2.3 ± 1.1
Grade by whom respondent taught:		
Senior house officer	17 (33%)	6 (14%)
Registrar	28 (54%)	31 (72%)
Senior registrar	5 (10%)	3 (7%)
Consultant	2 (4%)	3 (7%)
Number respondent has taught	4.2 ± 4.5	2.9 ± 4.3
Grade of those taught:		
Pre-registration HO	44 (98%)	18 (72%)
Senior house officer	24 (53%)	22 (88%)
Registrar	2 (4%)	6 (24%)

STEPHEN WHEATCROFT
Senior House Officer
City Hospital, Birmingham
SIMON MAXWELL
Senior Lecturer
Leicester Royal Infirmary

Complementary medicine

Editor—We have recently undertaken a survey of rheumatologists and private medical insurers regarding their policies for reimbursement, with specific reference to disciplines within alternative medicine. The findings from our survey may be of interest to your readers in view of the articles on complementary medicine and discussion regarding a dialogue with orthodox medicine (September/October 1996, pages 406–9).

The questionnaire (sent to 100 rheumatologists, 71 responded) included enquiries regarding the rheumatologists' knowledge and preference of any particular discipline within complementary medicine. Acupuncture was the most popular discipline (n = 42; 66%), next in line came osteopathy (n = 24; 43%) and the Alexander technique (n = 18; 37%). Rheumatologists tended to refer to these disciplines more frequently than others; over a third of them felt that osteopathy, and over half that acupuncture, should be made available on the NHS. The teaching of certain disciplines, for example acupuncture, to physiotherapists as well as medical students, was generally supported by the rheumatologists. Other complementary therapies were considered less desirable.

Osteopathy, acupuncture and chiropractic were generally

considered by the rheumatologists to be more effective in rheumatic complaints management than others. Rheumatologists tended to refer patients to these disciplines after conventional treatment and only rarely on initial consultation by the patients. Only a quarter of respondents knew that private medical insurers paid for certain forms of alternative medicine.

The following disciplines were paid for by the majority of the main private medical insurers: chiropractic, osteopathy, homeopathy, acupuncture and Alexander technique; naturopathy, herbal medicine and others were paid for infrequently. Consultant referrals only were accepted in some disciplines, eg acupuncture, homeopathy and Alexander technique, while other disciplines, eg herbal medicine, naturopathy, reflexology and aromatherapy were not paid for, even on consultant referrals.

As indicated in your articles, the main political parties in this country support the incorporation of some of the disciplines, especially osteopathy and chiropractic, into mainstream medicine [2]. Many of these disciplines are particularly popular with the general public [3].

Surveys such as ours amongst other specialist groups within orthodox medicine are warranted so that contracting and commissioning authorities can take into account the attitudes of the public as well as different specialists towards planning and purchasing complementary therapies in NHS trust hospitals.

References

1 Pal B, Morris J. Rheumatologists and complementary medicine. *Rheumatol in practice* 1996;summer:18–20.
2 Maxwell RJ. The osteopaths bill. *Br Med J* 1993;**306**:1556–7.
3 NN. Healthy Choice. *Which?* 1995; November:8–13.

BADAL PAL
Consultant Rheumatologist
JULIE MORRIS
Senior Medical Statistician
Devonshire Royal Hospital, Buxton

Editor—As a general practitioner researcher in the field of complementary medicine, and one who will be attending the conference on science-based complementary medicine at the Royal College of Physicians, I was struck by the contrasting attitudes expressed by Brewin and by Ernst and Katchpuk about complementary medicine (September/October, pages 406-9 and 410-12).

Research indicates that the majority of general practitioners and hospital doctors feel that complementary therapy should be available on the NHS [1] and recently the BMA has shown an open mind [2]. In the hope that the College conference is based on a more creative spirit of enquiry than that of Dr Brewin's editorial, I am looking forward to 22 January.

References

1 Perkin M, Pearcy R, Fraser J. A comparison of attitudes shown by general practitioners, hospital doctors and medical students towards alternative medicine. *J Roy Soc Med* 1994;**87**:523–5.
2 British Medical Association. *Complementary Medicine: new approaches to good practice.* Oxford University Press, 1993.

CHARLOTTE PATERSON
General Practitioner
Warwick House Medical Centre, Taunton

Tobacco: the third world war In response

Editor—It is most regrettable that Mark Edmonstone has misinterpreted my Lilly lecture, and as a result wrongly accuses me of 'wild and factually incorrect claims about the financial penalties of tobacco to society'. (November/ December 1996, pages 588–9)

In my Lilly lecture I said, and the *Journal* accurately reported, '. . . tobacco *always* brings considerable debit to their economy ...'. This was, and remains, 100% true. Nowhere did I claim, nor would I, that tobacco always brings a *net* debit to national economies.

Edmonstone's letter goes on to give examples of how tobacco incurs a debit to the UK economy, thereby supporting my very argument!

Another point to consider in the debit-versus-credit argument on tobacco is that most smoking occurs not in small wealthy western nations, but in developing countries, where the care of the ill and the elderly remains predominantly within the family (rather than being a financial burden to the state), and where few receive state pensions.

It is especially important to be scrupulously accurate where there is a powerful opposition to tobacco control, namely the commercial, transnational tobacco companies. I could not have survived working in tobacco control for 15 years if I ever once made 'wild and factually incorrect claims'.

JUDITH MACKAY
Director of the Asian Consultancy on Tobacco Control, Hong Kong

History of Rh

Editor—Dr Dodsworth's article on the history of blood transfusion services in the UK made interesting reading for more than one reason. The discovery of Rh (albeit not by the UK transfusion service), and the extraordinary impact this had on the morale and practice of transfusionists throughout the world (including the UK), is curiously downplayed. Again, what is in fact a complex issue, both in terms of priority of experimental findings and the personal interrelationships of those involved, has been oversimplified by attributing discovery of the Rh group purely to Landsteiner and Wiener [1]. There can be little doubt that Levine and Stetson [2] published the first report describing the polymorphism that is characteristic of this blood group system, while Landsteiner and Wiener [1] coined the term 'Rh'.

The whole story is of course much more murkily fascinating than this. Anyone interested in the history of Rh should re-read