perature is normal. Is there any reason why this common presentation cannot be referred to a clinic without any investigations, and advising the patient to return if things worsen? In the early stages, the acutely hot joint demands two priorities: exclusion of sepsis and appropriate pain relief. Of all the investigations listed, the only one that reliably helps acute decision making is the Gram stain; even if this is negative, the joint is probably going to be treated as a septic arthritis anyway. Surely clinical features such as rate of onset, progression, degrees of pain and tenderness, fever, and the presence of rigors, are of some value, given the limitations of all the other tests.

When is an X-ray of value? Radiology departments are tired of excess X-rays. Whether the film shows chronic joint disease or not will not rule out sepsis or haemarthrosis. If there are chronic changes on the X-ray they should not come as a surprise because the patient will have chronic symptoms. A fracture is of course a useful finding.

No guidelines are given for the differential diagnosis of septic joints from other conditions which can produce similar changes in vital signs and acute phase reactants. We are given no suggestion as to the merits and demerits of the listed investigations in differential diagnosis.

The difficulty with the management of the acutely hot joint, and the most important thing for the patient, is surely the correct diagnosis. In practice, the initial diagnosis is much more difficult than the initial treatment. In the acute phase the diagnosis is mainly clinical until a day or two later when the results of culture and crystal analysis are available.

As a non-rheumatologist frequently in diagnostic dilemmas with hot joints and little time, I wish the authors had said more about clinical methods of diagnosis and about selective investigation than devoting so much space to treatment and laboratory investigations.

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An improved 'interim discharge letter'—a successful outcome from audit

Sir—Dr Clements' description of the discharge letter now used at Llandough Hospital (April 1992, pages 169–71) is interesting as an outcome from audit. We, in City and Hackney, have been using a very similar multicopy carbonless discharge letter and during the last year have used it when discharging over 50,000 patients. Our format was arrived at without audit, but by agreement that it was obviously sensible to combine our existing discharge letter, coding and prescription forms, primarily to reduce the work of the staff in writing the demographic data onto three forms, but also to reduce the number of pieces of paper to be kept in the casenotes. We are aware that other hospitals are using similar forms, also independently of audit.

The combination form is not without problems. The quality of data entry onto these forms, particularly by the medical staff, is poor, even though medical effort has been considerably reduced. At the moment, doctors do not seem to regard data quality as their problem. For example, an audit of forms received by general practitioners in our district showed that only 16% were completed in full.

Unless doctors can be persuaded to take seriously their role in ensuring high quality documentation and communication because they are essential to good patient care, the government will be justified in believing that only financial penalties and incentives will be effective in the Health Service.

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Research in training posts

Sir—I write to question the current arrangements for funding research posts for physicians in training and to suggest a possible solution which may be of interest to your readers.

It is generally thought to be undesirable—and in most cases impossible—to undertake a satisfactory research project while in a full-time NHS post, and so a period of 2–3 years of full-time research is necessary. There should therefore be provision for a trainee to progress smoothly into a suitable research post. Unfortunately this is far from the case. Not only is there a lack of suitable projects, there is a shortfall in funding. The current system of awarding grants for medical research can result in trainees with no experience in applying for these awards being left with a draft project which has been rejected by all the appropriate grant-giving organisations. All too often an unsuccessful candidate is given no indication of the reasons for his or her failure and is therefore liable to make the same errors in the next application. The situation can then become self-perpetuating as all the grant-giving bodies request information on previous applications of the project; the knowledge that a project has been rejected before makes it less attractive to fundholders. Not only is this time-consuming for all concerned, it can be demoralising for the trainee. Even if successful, prospective researchers frequently face significant financial hardship if they have to move to a new area to take up their post. Why are trainees in research posts not entitled to removal expenses? Surely as part of the training of future consultants such posts should not incur financial penalty.

What can be done to improve this situation? In the current economic climate, it seems unlikely that more money will be forthcoming. Indeed, this is probably