CORRESPONDENCE

Intensive care: a specialty or a branch of anaesthetics? I McA Ledingham, FRCSed 1095	Health care for travellers S Carr-Hill, MD 1098	1987 campaign on hours of work N Marlow, MD 1100
Long term urethral catheterisation in the elderly T S J Elliott, MRCPATH, and others; N P R Gunasekera, MB, and J Andrews, MD 1095	Consultant accountability Gail C Grice, MRCP; Edwina Darnell 1098	Manpower R Menon, MB 1100
LMSSA: a back door entry into medicine? N R C Robertson, FRCP; P H Willcox, FRCP; W S Parker, MRCS; E Josse, FRCP 1096	Aftermath of Chernobyl M Dace, MB 1099	Drums begin to beat in the waiting list jungle J Wight, MRCP 1100
Abdominal aortic aneurysms J Collin, FRCS 1097	Retiring M K Thompson, FRCP 1099	The Savage inquiry J G Grudzinskas, MRCP 1100
Inoperable aortic stenosis in the elderly: benefit from percutaneous transluminal valvuloplasty M J Monaghan, MSc, and others 1097	Chlormethiazole and alcohol: a lethal cocktail C C Cook, MRCPsych, and M Lipsedge, FRCPsych 1099	Scientifically Speaking M B Skirrow, FRCPATH 1100
Overuse of monitoring of blood concentrations of antiepileptic drugs M J Brodie, FRCP 1097	Failure to observe statistical guidelines Cecilia C A Macintyre and Gillian M Raab 1099	Drug points Cardiac side effects of pentamidine (B J Boughton); Severe cholestasis associated with stanazolol (I A Greer and others); Psoriasisiform eruptions associated with penicillamine (J C Forgie and A S Hight); Hypertension in association with busulfan (J F R Barrett and M E Dalton) 1101
Effect of dietary cholesterol on plasma cholesterol concentration J I Mann, MD, and Jacqueline Edington, BSc 1098	Congenital rubella in babies of south Asian women in England and Wales Christine M Crawford, MRCP 1099	Correction: Dangers in treating hyponatraemia (Ghanem <i>et al</i>) 1101
	Guidelines on halothane Sir Abraham Goldberg, FRSE, and A W Asscher, FRCP 1100	

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- No letter should be more than 400 words.
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Intensive care: a specialty or a branch of anaesthetics?

SIR,—Professor Hugh Dudley expressed the view that, while the present ad hoc arrangements for delivery of intensive care can be efficient, future demands are likely to necessitate the emergence of the “specialist intensivist” (21 February, p 459). He envisaged a core of such individuals in administrative charge of units with other consultants serving in a part time capacity. The original or parent discipline of either group of consultants might be anaesthesia, medicine, or surgery. In this regard Professor Dudley’s comments are in line with the views of the interfaculty collegiate liaison group, although his advocacy of the devolutionary cause would not receive the group’s support.

My own belief is that the controversial issue of independence need not stand in the way of present progress. What is important is to encourage without delay the development of the training programmes recommended by the liaison group. This would enable the specialties concerned to begin to work together and, in due course, help to ensure a more uniform distribution of adequate intensive care facilities throughout Britain. Much good will and cooperation will, of course, be required for the proposed training schemes to get off the ground.

The multidisciplinary approach to intensive care has much to recommend it in terms of both patient care and medical training. In this hospital such a system, involving both senior and junior staff, appears to have survived more or less successfully the rigours of some 20 years. Throughout this period we have encountered no significant administrative or professional problems, and two recent retirement vacancies from different specialties have been filled without conflict (one of the concerns raised by Stoddart).¹ More importantly, the unit’s staff have benefited from the interdisciplinary exchange of clinical skill at the bedside, and the remainder of the hospital has benefited from the shared intensive care experience (thus

allaying, to some extent at least, the concern expressed by Professor Dudley). Indeed, we like to think that this close collaboration with our ward medical colleagues extends beyond our own hospital through the medium of our regional mobile intensive care service.

In spite of Britain’s proud record of research endeavour in anaesthesia, medicine, and surgery we do not share an equivalent international standing in intensive care (at least as judged by output of published papers). This regrettable fact is due, firstly, to the absence of a recognised training programme for those young people who would otherwise be willing, able, and enthusiastic contributors and, secondly, to a lack of academic commitment to what is undoubtedly one of the more exciting, rewarding, and worthwhile medical developments to emerge in recent years. The

opportunity to make good both these deficiencies rests with the decision makers at departmental, collegiate, and university level and with those responsible for implementing recommended training guidelines locally. Although there may well be a “variety of good reasons”¹ why the rate of progress in the development of intensive care should not be unduly rapid, there are also a variety of good reasons why it should be more rapid than at present. Not the least important of these is that it is in the long term best interests of patient care.

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1 Stoddart JC. A career post—with intensive therapy? *Anaesthesia* 1986;41:1181-3.

Long term urethral catheterisation in the elderly

SIR,—Dr R B Kinder describes the high incidence of bacteriuria and its various complications in elderly patients with urethral catheters (28 March, p 792). We have shown that long term urinary catheterisation with concomitant chronic urinary tract infections may also result in damage to the bladder epithelium.¹⁻³ The urothelial damage may be extensive, affecting large areas of the bladder surface, particularly in patients who have had urinary tract infections for longer than four months. This damage may predispose the bladder to the recurrent infections that these patients develop.

Dr Kinder also considered the role of bladder lavage, suggesting that lavage is unsuccessful in the treatment of bacteriuria but that it may reduce the incidence and severity of catheter bypass by preventing accumulation of debris. More recently, we

have confirmed the lack of efficacy of antiseptic bladder washouts for the treatment of bacteriuria and, in addition, found that bladder lavage further disrupted the already damaged urothelium in such patients (T S J Elliott *et al*, 10th international symposium on pyelonephritis). We used the number of urothelial cells exfoliated into the urine as a marker of bladder damage. Twelve patients with long term (longer than six months) indwelling catheters and recurrent urinary tract infections underwent bladder lavage with either noxythiolin or chlorhexidine solutions as part of their routine management. Immediately after lavage large numbers of urothelial cells, some in clusters, were found in the patients’ urine. Three patients were monitored on consecutive days for up to three weeks, during which time they underwent several washouts. Increased urothelial cell exfoliation oc-

Numbers of shed urothelial cells in urine of patient who had had a urinary catheter for longer than six months with concomitant *Providencia stuartii* chronic urinary tract infection. Freshly collected catheter urine samples were examined before and after bladder lavage with 2.5% (wt/vol) noxythiolin (indicated by arrows). An increase in urothelial exfoliation, with a subsequent decrease, followed each washout.

current after each lavage, followed by a subsequent decrease in cell shedding (figure). In addition, the washouts failed to eradicate the associated urinary tract infection.

These results show that lavage entailing active instillation of antiseptics into the bladder is not only ineffective in treating urinary tract infections but may also further disrupt the already damaged bladder epithelium, predisposing the patient to further infection. The mechanism for this urothelial damage is unclear but may be related to the mechanical forces of instillation and the effect of the antiseptics. It is clear, however, that the role of bladder washouts should be revised and that they should not be used merely to keep the urine of patients with indwelling catheters visually clear.

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- 1 Elliott TSJ, Slack RCB, Bishop MJ. Scanning electron microscopy of human bladder mucosa in both acute and chronic urinary tract infection. *Br J Urol* 1984;56:38-43.
- 2 Elliott TSJ, Slack RCB, Bishop MC. Bladder changes associated with urinary tract infections. *Lancet* 1985;i:1509.
- 3 Elliott TSJ, Slack RCB, Reed L, Bishop MC. Ultrastructure and bacteriology of the bladder in urinary tract infection. *Journal of Infection* 1985;11:191-9.

SIR,—Dr R B Kinder (28 March, p 792) highlights the multiple and perennial problems associated with catheterisation in the elderly, stating, "There may also be more serious complications such as sepsis, but few studies have attempted to assess the risk."

We undertook to study precisely that but immediately ran into several logistical problems. Firstly, there are no "universally accepted" criteria for catheterisation of the urinary bladder other than retention. Secondly, those incontinent elderly patients who "require" an indwelling catheter do not constitute a homogeneous group for such a study as multiple pathology is invariably present. Thirdly, what constitutes "infection" in the presence of an indwelling catheter is uncertain as the conventional levels of bacteriuria and pyuria taken to indicate infection in midstream samples of urine do not seem to apply to catheter samples.^{1,2}

Despite these obvious obstacles we attempted an investigation in one unit of women with no pyuria or bacteriuria at initial catheterisation. Over nine months we found only 14 suitable patients. All developed considerable pyuria within 48 hours and bacteriuria of over 10^5 colony forming units/ml within 72 hours of catheterisation. Eight died within three months of catheterisation from various causes. In the six survivors with indwelling catheters bacteriuria and pyuria persisted and failed to clear spontaneously for up to three months after the catheter was removed. Antibiotic treat-

ment eventually eliminated both bacteriuria and pyuria.

We believe that the only means of assessing long term sequelae of urethral catheterisation in terms of "sepsis" is a larger, multicentre study with well defined criteria. Until such a study is undertaken the hazards of long term urethral catheterisation in the elderly must remain uncertain.

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- 1 Stark RP, Maki DG. Bacteriuria in the catheterised patient. What quantitative level of bacteriuria is relevant? *N Engl J Med* 1986;311:560-4.
- 2 Grimond TR, Sinclair G, Marshall VR. Catheter associated urinary infections. In: Watts JMcK, ed. *Infection in surgery: basic and clinical aspects*. Edinburgh: Churchill Livingstone, 1982.

LMSSA: A back door entry into medicine?

SIR,—Mr Richard Wakeford's article on the LMSSA and other "back door entries into medicine" can be justified only (4 April, p 890) if three things are true.

Firstly, the final MB is, or should be used as, an effective method of preventing unsuitable people from permanently entering the medical profession. Secondly, there is good evidence that medical students benefit from spending an extra six months before they qualify, usually because they have failed just one component of their final examinations. Thirdly, there is evidence that any doctor using the LMSSA, conjoint, or Scottish triple examination as a preliminary, or even sole, way of qualifying has done anyone any harm.

The first postulate is clearly not true. There are a few people taking the MB who are inappropriate for careers in medicine. That they get that far is, by and large, an indictment of the admission procedures to medical school and the lack of appropriate counselling by medical school deans during the course. Using the final MB to weed out such people is inappropriate and ineffective. Such people, whatever their other deficiencies, are intelligent and will qualify sometime and somehow; whether this is by the MB (which most pass) or LMSSA is irrelevant.

The second postulate is also untrue. It is crystal clear that at least half the students who fail "finals" have had an off day, usually in just one subject. Everyone will remember able people in their own years at medical school who failed some part of finals yet clearly should not have done so; passed the subject 6 months later after wasting six months of their lives (unless they had the LMSSA or MRCS, LRCP); and indeed often rose to positions of great eminence in the specialty they failed. Mr Wakeford, as an expert in examination methods, surely cannot believe that even the Cambridge MB is a perfectly adequate way of assessing whether someone is fit to practise. Many medical schools have come to the conclusion that

"finals" are a poor way of assessing fitness to practise and have therefore abandoned them. Anyone who knows anything about being a medical student and a preregistration house officer recognises that you learn more in a fortnight as a house officer when the chips are down than in six months as a student. If someone is up to being a doctor—as are most people who fail finals first time—then they might as well qualify and learn their trade under supervision in their preregistration year rather than spend six months floating around the medical society bar.

The third postulate is in many ways the most serious and provocative, since the implication is that holders of the LMSSA are unfit to practise. Has Mr Wakeford any evidence that they are any less competent than holders of a university degree?

My final objection is a more philosophical one. There is a depressing tendency in Britain in the 1980s to create the homogeneous (or do I actually mean homogenised) doctor. We all must sit similar A levels, take similar MB exams, do similar routine jobs approved by boring higher training committees that give the impression they know little about medical education, all with the aim of producing the identikit accredited GP, paediatrician, or whatever. How awful, how boring, and how little evidence there is that this "homogenisation" is doing any good. To allow someone to qualify in a slightly unusual way must be allowed since it is clear that it does no harm.

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SIR,—I was astonished that you agreed to publish the article by Mr Richard Wakeford on the LMSSA (4 April, p 890) with the absurd hypothesis which has been demolished by our Master (18 April, p 1035). There are other facts, however, of which Mr Wakeford should be aware. Students often take their final examinations under financial stress and need to qualify quickly to obtain hospital appointments by a certain date. The experience of the 10 cases quoted is thus easily explained. The interval between the examinations allows time enough for further study so that candidates may pass at the second attempt. Moreover, final examinations are not so much tests of ability as tests of the basic medical knowledge that a doctor requires to work under supervision in recognised hospitals before, after completing several approved appointments, he is allowed, on full registration, to serve the public independently.

When I qualified, in 1935, there were discrepancies in the standards of the final examinations held by different bodies. It was common knowledge that the London MB BS was the hardest to pass (about 30% of candidates or less), Oxford the easiest, and Cambridge and the LMSSA somewhere in between. These discrepancies were, of course, corrected after the war by the General Medical Council; standards were equalised and are nowadays reviewed regularly.

Far from being a backdoor entry into medicine, the Society of Apothecaries' qualification offers a useful service to the student who cannot afford a delay of six months before his second attempt. To argue that the LMSSA is a second rate qualification is a serious criticism of the General Medical Council and is like arguing with a referee as the council keeps standards under firm control. It is therefore not a matter worthy of debate in the journal of the BMA.

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SIR,—There is a converse to Mr Richard Wakeford's somewhat lofty criticism of qualifica-