changing pattern of population and of diseases to be able to practise good clinical medicine. Sadly, there is no sign of integration of geriatric medicine into the present curriculum of undergraduate training in most of the universities in this country. So far "geriatric medicine" is being kept outside the main stream of medical specialties, but as the elderly population will increase in the 1980s there will be a need for improving and enlarging the geriatric specialty at a much faster rate than at the present time. The teachers of geriatric medicine should be able to train the present and future generation of medical undergraduates in a right and proper way to help them to become good clinicians who will understand the special problems and needs of the elderly community.

Firstly, how can geriatric medicine best be taught? One cannot become a good geriatric clinician by only listening to lectures away from patients. So it seems that the best way to learn the problems and management of elderly patients would be to attend ward clinics and bedside clinical case demonstrations. Secondly, at what level can the student benefit most? This is also controversial, but I do not believe that only senior medical students should be involved in geriatric training programmes. Geriatrics should be considered as similar to any other clinical specialty and students should start learning the skills from their first clinical year. Lastly, there should be more examiners in undergraduate and postgraduate examinations from the geriatric specialty to achieve a balanced training programme for clinical medicine as a whole.

B C KUNDU

Department of Geriatric Medicine,
King's College Hospital,
London SE5

Ventricular tachycardia during exercise testing

SIR,—We were interested to read of the incidence of ventricular tachycardia during symptom-limited exercise testing reported from the Hammersmith Hospital, (9 September, p 733). We are concerned that their results might be misinterpreted as evidence against graded exercise in patients with known coronary disease. This, of course, is not the message of the paper by Dr Stephen Talbot and his colleagues but in these days of increasing interest in and enthusiasm for exercise we would like to report briefly our own experience of ventricular tachycardia during exercise testing. Over the last few years, we have exercise tested 285 patients six weeks after discharge from hospital, following acute myocardial infarction, and these patients have subsequently been retested on 594 occasions. Ventricular tachycardia, by which we mean three consecutive ventricular beats, has been recorded during testing on only two occasions, and on both has ceased spontaneously. Our method of testing was different from that of the Hammersmith group since, if no symptoms developed, exercise was stopped at 85% of the age-predicted maximum heart rate (for example, for a 50-year-old man, the test would be stopped at a rate of 151 beats/minute). Our test was also different in that it was on a bicycle ergometer rather than a treadmill, but this is probably irrelevant. Our lower incidence of ventricular tachycardia cannot be compared

with the Hammersmith series since the selection was different, as was the method of testing. We merely wish to make the point that the incidence of ventricular tachycardia, a potentially lethal arrhythmia, is low in patients after recovery from myocardial infarction. Indeed, with our system of testing neither this arrhythmia nor any other results from the exercise tests have led to any patients being excluded from our subsequent exercise rehabilitation course. Our contraindications to testing and the subsequent course include such obvious features as heart failure and severe or prolonged angina during the convalescent period. In those who are overtly well, however, the incidence of ventricular tachycardia with submaximal testing has been extremely low.

PETER CARSON
ROSALIND PHILLIPS

Cardiac Department,
City General Hospital,
Stoke-on-Trent

"Crucifixion" crucified

SIR,—I read in your correspondence columns (7 October, p 1024) a statement that a consultant has been "publicly crucified." Ritual murder is a crime in this country and I hope therefore that the murderer, who is identified by office, will soon be brought to trial.

Seriously though, sir, some analogies are unacceptable, and this is one of them. The word "crucified" has a narrow and precise meaning; it is not a suitable word to be used in place of "held up to public obloquy" or "public vilification" or "publicly accused of infamous behaviour." I am surprised that a presumably educated person should misuse the word in such a way, and that you, sir, should permit this misuse to appear in print.

GEORGE DISCOMBE

Haywards Heath, Sussex

* * Dr Discombe's rigid interpretation of the term "to crucify" is not shared by, for example, *Chambers Twentieth Century Dictionary*, which includes together with the more literal definition "to subdue completely: to mortify: to torment."—ED, *BMJ*.

Polymorphism in drug metabolism

SIR,—We were very interested by the paper of Mr T P Sloan and colleagues on the polymorphism of carbon oxidation of drugs and its clinical implications (2 September, p 655). Their findings might also be clinically important for beta-blocking drugs, especially if they are metabolised to active compounds.¹ Of nine healthy volunteers studied by our group, one was a poor metaboliser in respect of aromatic hydroxylation of tolamolol and aliphatic hydroxylation of bufuralol. It was interesting to note that this subject also showed an exaggerated sensitivity to the effects of these two beta-blocking agents. We thus fully agree with the conclusions of Sloan and his colleagues that the current practice of using hybrid pharmacokinetic parameters such as the apparent elimination half life or whole-body clearance is "singularly ineffective" in detecting interindividual variations in drug metabolism. As a matter of fact, for both drugs our "outlier" subject showed

metabolite plasma levels significantly lower than the other subjects, the other overall pharmacokinetic parameters being within normal limits. We consequently advocate that, whenever technically feasible, at least one metabolite should be monitored for the pharmacokinetic study of drugs which are extensively metabolised, whether this metabolite has pharmacological activity or not.

L BALANT
P DAYER
J FABRE

Policlinique Universitaire de Médecine,
Geneva

¹ Balant, L, et al, *Schweizerische Medizinische Wochenschrift*, 1976, **106**, 1403.

Breathing other people's smoke

SIR,—Mr Sherridan L Stock (2 September, p 699) drew attention both to the nuisance value and health hazard arising from ordinary domestic bonfires. These are an increasing problem, especially in urban areas, where gardens seem to be getting smaller and smaller, with the result that space for the storage of waste, including compost, is often at a premium. The policies of the collection and disposal authorities have not helped either, as the former seem sometimes only to be prepared to take less and less, while the latter so often have their disposal points at such inaccessible sites that people are just not encouraged to take their refuse for proper disposal. The result is that more refuse is being burned in people's gardens than need be.

Although, as it happens, my authority has a very good and accommodating refuse collection system, it also has a continuing environmental health education programme which includes reference to bonfires. This involves the wide distribution and display of leaflets and posters and over the past few years there have been definite indications that the message is getting through and that less nuisance is being caused or, perhaps more important, that it is not increasing despite the reasons why it might be. One of the leaflets, for example, advises members of the public on the advantages to be gained from composting refuse, while another gives full information on how they may dispose of any awkward household waste which might otherwise be burned on the bonfire. Early attention to persistent offenders is important and we find that, once approached, most people acknowledge the problem and accept the advice of officers on how to dispose of their refuse more sensibly and less offensively.

GRAHAM ASTON
Borough Environmental Health
and Housing Officer

Borough of Epsom and Ewell,
Surrey

SIR,—As medical officer for environmental health and chief environmental health officer to a district council, we would not like your readers or Dr Sherridan L Stock (2 September, p 699) to think that he is "conducting something of a lone battle against the bonfire." Before local government reorganisation and since, the local councils in this part of Buckinghamshire, noted for its trees and beech woods, have publicised the works of Professor Pybus and the Henry Doubleday Association. The leaflet *Give Up Smoking Bonfires—Make Compost and Leafmould*