and the medical director have regular clinical contact.

Finally, to assume that many of the duties now carried out by medical directors were previously in the remit of directors of public health indicates a considerable misunderstanding of the role of medical directors.

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1 Beecham L. BMA advises medical directors. *BMJ* 1994;308:724.
(12 March.)

Study leave for junior doctors

Academic staff get a raw deal

EDITOR,—David P Coates's letter on study leave¹ and the abridged paper on study leave for postgraduate trainees² highlight the problems associated with the funding of discretionary study leave for doctors in the postgraduate training grades employed in the NHS. We wish to highlight the difficulties experienced by trainees employed on university contracts, some of whom experience financial hardship resulting from the lack of clearly defined budgets to fund their study leave. Only three of the 15 health districts surveyed by the Standing Committee on Postgraduate Medical Education made any provision for funding study leave taken by academic medical staff.³

We posted a standard questionnaire, which was distributed across all specialties, to clinical lecturers holding honorary senior registrar contracts who worked in the John Radcliffe Hospital, Oxford, during 1992. We obtained a 67% response (22/33); 15 replies were usable. The mean number of study leave days taken to attend courses and conferences in the previous year had been 6.5 (range 0-19) days. Only eight of the 15 respondents received full reimbursement of expenses; the remaining seven had had to pay on average £252.50 (range £90-£560) themselves.

Study leave remains an essential medium for postgraduate training. Our study found that the provision of funding for academic trainees was not uniform; this may result in a restriction of training opportunities to some medical staff employed by universities.

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- 1 Coates DP. Study leave difficult to fund. *BMJ* 1994;308:596. (26 February.)
- 2 Temple J, Easmon C, Johnson R, Triger D. Study leave for postgraduate trainees. *BMJ* 1994;308:facing p 596 (clinical research edition), facing p 598 (general practice edition), facing page 581 (compact and international edition).
- 3 Standing Committee on Postgraduate Education and costs of study leave. *Results of a retrospective survey of 15 health districts in England*. London: SCOPME, 1991.

Leave should be protected and fully funded

EDITOR,—As a career surgical registrar I was disturbed to read David P Coates's letter suggesting that, because the contracted working week has been reduced to two thirds of its original hours, the time may have come to reduce annual study leave to 20 days.¹ The letter was in the same issue as the abridged paper by John Temple and colleagues suggesting that trainees who have already acquired basic postgraduate qualifications require short courses in management awareness, audit techniques, computer literacy, etc, in addition to the

intensive "hands on" courses required by many surgical specialties.²

The reduction in junior doctors' working hours under the new deal is aimed at providing a safe service supported by senior house officers who are not overstretched and tired, cut in study leave and more independent study after hours surely brings us back to square one. A more sensible approach might be to include a clause when trust hospitals are set up to ensure that such study leave for the next generation of consultants is not only protected but also more adequately funded.

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- 1 Coates DP. Study leave difficult to fund. *BMJ* 1994;308:596. (26 February.)
- 2 Temple J, Easmon C, Johnson R, Triger D. Study leave for postgraduate trainees. *BMJ* 1994;308:facing p 596 (clinical research edition), facing p 598 (general practice edition), facing p 581 (compact and international editions).

Allitt inquiry

EDITOR,—We were disappointed to read Clare Dyer's article on the inquiry into the murders of children by nurse Beverly Allitt.¹ We believe that Dyer portrayed us unfairly by highlighting all the criticisms made about us in the report. It is unlikely that many busy medical professionals will get a chance to read the report in detail; thus the abstracts and the comments presented must be balanced and fair. In the report the panel praised our clinical skills and dedication, our "high standard of teaching and training" of junior doctors and nurses, and the "high standard of [our] record keeping." The panel also commended us for saving, through our "skill and persistence," some babies who would otherwise have "suffered death or permanent injury."

Sir Cecil Clothier and Mrs Virginia Bottomley stated publicly that no individual person is to be blamed or scapegoated, yet we seem to be the victims of some of the publicity since the inquiry.

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- 1 Dyer C. Inquiry into serial killer criticises hospital's response. *BMJ* 1994;308:491. (19 February.)

Snoring and sleep apnoea

EDITOR,—The clinical advice given by N J Douglas reflects the approach of most physicians and ear, nose, and throat surgeons to an obese middle aged man who snores to the extent that the marital relationship may be threatened.¹ But Douglas undervalues the contribution of an ear, nose, and throat surgeon, who may be able to cooperate with the patient, general practitioner, and respiratory physician to advise on an integrated plan of management to reduce the snoring.² Certainly, when sleep apnoea rather than "heroic" snoring is suspected, full investigation in a sleep laboratory should be advised.

A considerable number of patients who snore need to lose weight and reduce their alcohol intake and tobacco consumption. There is, however, a residual group in whom symptoms do not improve despite these essential measures. Not all of these snorers require major palatal surgery, but investigation of the nasal airway, nasopharynx, and paranasal sinuses is essential to exclude allergic or perennial rhinitis, nasal polyposis, or anatomical obstruction of the nasal airway. Indeed, nocturnal continuous positive airway pressure may be of little benefit if the nasal airway is appreciably obstructed.³

When an oropharyngeal abnormality is present in those who do not respond to non-invasive measures uvulopalatopharyngoplasty, which was described many years ago,⁴ is successful in abolishing heroic snoring in about two thirds of selected patients. The morbidity associated with this operation is minimised by careful selection and preoperative assessment of patients, close cooperation with an experienced anaesthetist, and high dependency nursing in the postoperative period.⁵ The risk of death under these circumstances should be very slight.

Advising that the onus for improving symptoms should be placed on the patient gives an unrealistic, negative view of the management of this common problem. Snoring is a common, socially disabling, and potentially harmful condition for which the sufferer and his or her partner should be offered available treatment—social, medical, and surgical—when appropriate.

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- 1 Douglas NJ. Any questions. *BMJ* 1994;308:640. (5 March.)
- 2 Orr WC, Moran WB. Diagnosis and management of obstructive sleep apnoea. A multidisciplinary approach. *Arch Otolaryngol* 1985;111:583-8.
- 3 Rubin AHE, Eliaschar I, Joachim Z, Lavie P. Effects of nasal surgery and tonsillectomy on sleep apnoea. *Bulletin Européenne de Physiopathologie Respiratoire*. 1983;19:612-5.
- 4 Fujita S, Conway W, Zorick F, Roth T. Surgical correction of anatomic abnormalities in obstructive sleep apnoea syndrome: uvulopalatopharyngoplasty. *Otolaryngol Head Neck Surg* 1981; 89:923-4.
- 5 Fairbanks DNF. Uvulopalatopharyngoplasty. Complications and avoidance strategies. *Otolaryngol Head Neck Surg* 1990; 102:239-45.

Advertising on hospitals

EDITOR,—I am amused by the stuffy letter from Charles Warlow about the sign on Auckland Hospital in New Zealand.¹ The hospital seems fairly clean looking (Sharp looking perhaps). If the grubby NHS hospitals that I have seen on my occasional visits to Britain are anything to go by, the revenue from such advertising could be well used to clean them up. As I remember, Edinburgh on my last visit (in 1992) was the grubbier place of all.

Last year I spent some time working with children's surgeons in Budapest. There was a similar sign high on the hospital, which brought much needed revenue from a Far Eastern electronics firm. It was one of the many things that made me think that Hungary would survive its economic trials. I can't say the same for the NHS. A little more verve and a little less of the "good old days" attitude and the NHS wouldn't be slipping away through Warlow's fingers.

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- 1 Warlow C. Sharp advertising. *BMJ* 1994;308:472. (12 February.)

Correction

Infection with hepatitis C virus

Three printer's errors occurred in the letter by Nicholas Hallam and others (26 March, p 856). The enzyme linked immunoassay used to confirm positive test results (mentioned in the third sentence) was the Murex BHC11 immunoassay, not the Murex BCJ11 as published. In the table the asterisk should have appeared in the heading of the third column after "Reverse transcriptase/polymerase chain reaction" and the final footnote should have read, "†Twenty four reactive to c22, 13 to c100-3, seven to c33."