examine a woman who had been involved in a vehicle accident on her way to the airport. The accident was sufficiently violent to have fractured a long bone. Despite having "attended an advanced trauma and life support course" he failed to examine the patient properly—on his own admission he did not carry out a full primary survey of the patient at the outset. Nor did he insist that the patient be transferred from the plane for a proper evaluation, which would have been simple and taken only a few minutes.

Admittedly, the "Heath Robinson" chest tube drainage that he performed during the flight was ingenious, but what if she had had a ruptured liver or spleen? His Sellotape and coat hanger would not have helped then. Surely the best way of managing an in flight emergency is to avoid it if at all possible.

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1 Wallace WA, Wong T, O'Bichere A, Ellis BW. Managing in flight emergencies. *BMJ* 1995;311:374-6. (5 August.)

Professor Wallace's reply

EDITOR,—When I was first asked to examine Paula Dixon she was complaining only of pain in the right forearm. She told me that she had injured her right forearm when she fell off her bike on her way to the airport. I assumed, incorrectly, that she had fallen off a bicycle and had injured the forearm while breaking her fall. It was only later (during the flight) that we learnt that she had been a passenger on a motorbike and had been thrown from it when it was in collision with a car. I have found, since this episode, that it is fairly common for airline passengers to conceal the truth if there is any possibility that they might be taken off their flight, and it is important for doctors to be fully aware of this.

Paul D Buisseret is right in highlighting the fact that I had been on an advanced trauma and life support course and yet failed to carry out a primary survey. There were three reasons for this. Firstly, Ms Dixon had not told me about the motorcycle accident and reported no problems other than that with her forearm; secondly, she was seated at the rear of the aircraft, which had no empty seats and little space available, although I could have carried out an acceptable primary survey with her seated; and, finally, Ms Dixon could easily have construed a primary survey examination of her limbs, spine, pelvis, and chest as misbehaviour. Doctors often forget how much easier it is to carry out such examinations either at the scene of an accident or in hospital.

In retrospect, perhaps I should have transferred Ms Dixon from the plane (thereby causing her to lose her economy flight home), but I took the action that I believed was correct on the basis of the information available to me. Perhaps others will learn from my experience and be slightly more cautious when called on to give medical help.

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American cardiothoracic trainees want longer hours too

EDITOR,—We are currently visiting England from the United States and training as senior surgical registrars in paediatric cardiac surgery at Great Ormond Street Hospital. As interested external observers of the British system of medical training, we strongly support the letter from the British

senior registrars in cardiothoracic surgery.¹ Like them, we believe that "cardiothoracic surgery is by reputation, and often in practice, an arduous specialty."

We think that technically oriented subspecialties such as cardiac surgery are different from most subspecialties because the trainees have to learn certain skills by repeating tasks in highly supervised settings. Consequently, it is not logical to place the same constraints on hours on these advanced subspecialties as are placed on most postgraduate training programmes. Certain exceptions to the standard constraints on working hours are necessary to allow cardiac surgeons in training to acquire the necessary skills and to gain exposure to rare cardiac lesions. They must be exposed to this work if they are to be safe and productive cardiac surgeons.

We have done many years of training since leaving medical school. This year's workload has been by far the lightest. Nevertheless, we have been told that we may be working more hours than we should. Unfortunately, this comes at a time when increased exposure to operations would be useful.

Great Ormond Street Hospital has an international reputation for training the best paediatric cardiothoracic surgeons in the world; limiting the hours of exposure will dilute their overall experience and compromise their training. Similarly, placing severe restrictions on the working hours of cardiothoracic surgeons in general threatens their training. We agree with our British colleagues that "not all hospital based specialties are similar." Furthermore, not all hours on call are similar. Thus we agree that all junior doctors in all specialties should not be governed by the same regulations, because each specialty is unique.

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1 Alkhulaifi A, Allen SM, Anderson JR, Argano V, Austin C, Barlow C, *et al*. New deal not satisfactory for cardiothoracic surgery. *BMJ* 1995;311:953. (7 October.)

Continuing confusion over the eponymous possessive

EDITOR,—Despite discussion in the medical press for many years the use of the possessive form for eponymous syndromes and diseases remains as confused and inconsistent as ever. For example, some medical dictionaries, such as Black's, consistently use the possessive form whereas others, such as Jablonski's, equally consistently use the non-possessive.^{1,2} *Index Medicus*, which might be expected to be authoritative, is hopelessly inconsistent, listing some possessive forms (for example, Alzheimer's, Hodgkin's, Huntington's, Klinefelter's, and Turner's) and some non-possessive forms (Crohn, Down, Marfan, Parkinson, and Rett).³ Fanconi appears in the possessive form for the anaemia but not for the syndrome. Nor is current or recent use much help. A search of titles in the *Science Citation Index* for 1981-5 and 1991-5 shows that the use of the possessive has decreased for chromosomal syndromes—from 60% to 52% for Down's, from 74% to 62% for Klinefelter's, and from 64% to 42% for Turner's. Huntington's has also decreased slightly, from 82% to 76%.⁴ Alzheimer's and Hodgkin's, however, have remained steady at about 90% and 95% respectively, while Parkinson's has increased from 87% and is now (despite *Index Medicus* and Jablonski) almost universal at 98%.

I have no strong views about which form is preferable. The lack of consistency, however, causes needless complications when one searches the literature. Is it not time for the editors of the major medical journals to come to an agreed position and to issue firm guidelines on use?

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- 1 Macpherson G, ed *Black's medical dictionary*. 37th ed. London: A and C Black, 1992.
- 2 Jablonski S. *Jablonski's dictionary of syndromes and eponymic diseases*. Malabar, FL: Krieger, 1991.
- 3 National Institute of Health. *Medical subject headings, supplement to Index Medicus*. Vol 36. Bethesda, MA: NIH, 1995.
- 4 Institute for Scientific Information. *Science citation index*. Philadelphia: ISI, 1995.

Corrections

Asking patients to write lists

A typesetting error occurred in the first letter in this cluster, by Alejandro R Jadad (16 September, p 746). The P value given in the middle of the penultimate paragraph should read $P < 0.05$ [not $P \geq 0.05$, as published].

Volume and mortality in coronary artery bypass grafting

An authors' error occurred in this letter by Harold S Luft and Jennifer D Parker (11 November, p 1304-5). The y axis in the figure was incorrectly labelled and shows the ratio of observed to expected mortality [not mortality adjusted for risk, as published].

Differences in progression of HIV infection between men and women

Owing to a typesetting error the table was omitted from this letter by Matthias Egger and colleagues (8 April, p 941). The table, which is mentioned in the penultimate paragraph, is reproduced here.

Details of subjects with disseminated cytomegalovirus infection among participants in Swiss HIV cohort study who were infected by injecting drug use or heterosexual sex and were free of AIDS at entry to study

	Women (n=998)	Men (n=1469)	P value
Characteristics of patients at entry:			
No (%) of injecting drug users	534 (54)	1013 (69)	<0.001
Mean (SD) age (years)	28.9 (6.6)	31.0 (6.8)	<0.001
Mean (SD) CD4 cell count ($\times 10^6/l$)	504 (34)	446 (33)	<0.001
Disseminated cytomegalovirus disease:			
Total No of events	4	12	0.2
No of AIDS defining events	0	5	0.07
Relative rate (95% confidence interval)*	0.57 (0.18 to 1.83)		0.34

*From Cox regression, including all events; comparing women with men; and adjusting for category of transmission, age, and CD4 cell count.