

Training of overseas qualified doctors in Britain

EDITOR,—The changes in postgraduate training for British graduates that are about to be implemented with the introduction of the specialist registrar grade offer an opportunity to achieve the goal of "planned, coordinated, and tailored" training for overseas qualified doctors.¹ It will require not only commitment but funding.

The way forward is to integrate overseas trainees into regional training programmes in a way that complements the experience they can obtain in their own country. The specialty of urology receives many requests from overseas doctors for training in Britain; unfortunately, for historical reasons it has virtually no spare capacity in its higher surgical training programmes. Nevertheless, many overseas doctors have been accommodated by being offered senior house officer posts or registrar posts not recognised for higher surgical training. With the implementation of the Calman proposals even these opportunities will disappear.

An increase in training posts is urgently needed to meet the burgeoning demand for urology services and to reach the modest target of one consultant per 100 000 population. During this period of expansion, which is likely to continue for at least 10-15 years, the training of overseas doctors will virtually stop unless some additional numbered posts are specially allocated and funded. The creation of just two such overseas posts per region would be a considerable contribution and would have the additional benefit of enabling British trainees to take full advantage of the "one year off service" that the training programme allows. This would be a splendid opportunity for the NHS and the profession to foster international good will and to contribute to the needs of the developing world.

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1 Holcombe C, Watters DK. Training of overseas qualified doctors in Britain. *BMJ* 1995;311:642-3. (9 September.)

Urban hypothermia

Many elderly people cannot keep warm in winter without financial hardship

EDITOR,—L J Hislop and colleagues' finding that patients who were found hypothermic inside their own homes were mainly elderly people who had heating available but were not using it is of great concern.¹ We have performed a questionnaire study of domestic heating, in which 200 mentally competent elderly inpatients were interviewed (mean age 82).² All were admitted to acute geriatric wards last winter. Most patients (138) were aware that value added tax was added to their fuel bill, and 62 said that they had reduced the amount of heating they used because of this. A third of patients said that they had had difficulty keeping warm before admission. Most (128) said that they could not manage to keep warm in winter without financial hardship. In addition, 58 said that they had reduced amounts spent on food in order to pay for fuel bills. Important factors associated with feeling cold before admission included living alone, owning their own property ($P < 0.02$), and using coal as their main fuel ($P < 0.02$). Only one patient had a diagnosis of hypothermia.

Some elderly people do not use their domestic heating during cold weather because of concern about the increasing cost of fuel. Since cold is associated with lowered resistance to infection and reduced functional mobility³ it may contribute to

hospital admissions among older people due to falls, respiratory infections, etc.

Elderly people need to be encouraged to use domestic heating during cold weather. Since a major deterrent seems to be concern about cost, the issue of payment for domestic fuel by elderly people needs to be addressed. Perhaps domestic heating should be subsidised for older people or value added tax on fuel should be abolished for senior citizens (at least for those who do not pay income tax) as the losses may be offset by a reduction in the number of hospital admissions. This not only could provide a cost saving but, more importantly, might result in a reduction in morbidity and mortality caused by low environmental temperatures in older people.

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- 1 Hislop LJ, Wyatt JP, McNaughton GW, Ireland AJ, Rainer TH, Olverman G, *et al* for the West of Scotland Accident and Emergency Trainees Research Group. Urban hypothermia in the west of Scotland. *BMJ* 1995;311:725. (16 September.)
- 2 Morgan R, Blair A, King D. Winter survey of domestic heating in elderly patients. *J R Soc Med* (in press).
- 3 War Office. *Manual of army health*. London: HMSO, 1959:85-8.

Number of excess deaths during winter is large

EDITOR,—In discussing the incidence of hypothermia L J Hislop and colleagues touch on the larger issue of excess deaths in winter.¹ Research in many countries has confirmed this phenomenon,^{2,4} which can be ascribed only in part to hypothermia itself and the effects of influenza and other respiratory infections.² A major factor seems to be the effects of cold stress on the cardiovascular system.^{3,4}

The figures for deaths from all causes and from ischaemic heart disease during summers (April-September) and winters (October-March) over the past five years give some indication of the size of this problem in Scotland (table). Between 1989 and 1994 the winter excess of deaths from ischaemic heart disease was over 1000 annually, rising to nearly 1500 in 1993-4. The winter excess of deaths from all causes reached 7382 in 1989-90 but has usually been between 3000 and 4000 (an epidemic of influenza probably accounted for the high figure in 1989-90).

These Scottish figures, if extrapolated, support the contention of the charity Help the Aged that each year in Britain at least 30 000 people aged over 65 die as a consequence of winter conditions.⁵ The figures give some indication of the true consequences of "fuel poverty"—poverty being the

operative word as the harmful effect of cold stress is ameliorated by higher income.³

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- 1 Hislop LJ, Wyatt JP, McNaughton GW, Ireland AJ, Rainer TH, Olverman G, *et al* for the West of Scotland Accident and Emergency Trainees Research Group. Urban hypothermia in the west of Scotland. *BMJ* 1995;311:725. (16 September.)
- 2 Kunts AE, Looman CW, Mackenbach JP. Outdoor temperature and mortality in the Netherlands; a time series analysis. *Am J Epidemiol* 1993;137:331-41.
- 3 Larsen V. Short term fluctuations in death by cause, temperature and income in the United States, 1930-1985. *Social Biology* 1990;37:172-87.
- 4 Goudas Y, Deklunder G, Lecroart JL. Cold exposure and ischaemic heart disease. *Int J Sports Med* 1992;13 (suppl 1): S179-81.
- 5 Winter. London: Help the Aged, 1994. (Information sheet 17.)

Prioritised ambulance call out may be necessary

EDITOR,—Alison Tonks's report on a new system for answering emergency calls to the ambulance service¹ coincided with a survey into the use of emergency ambulances to reach the accident and emergency department at the General Infirmary at Leeds. The survey aimed to seek evidence of inappropriate use of the service. Details of all patients arriving at the department by emergency ambulance were collected over 14 days, notes were then retrieved, and departure details were recorded.

A total of 831 patients were brought in by emergency ambulance during the study period; two of these had incomplete records and were excluded from the analysis. Of the remainder, 274 had been referred by a general practitioner and 555 came in after a 999 call. Seventy (26%) of the patients referred by a general practitioner were discharged home, while 291 (52%) of those brought in after a 999 call either were discharged home or left the department. Of those brought in after a 999 call who were discharged, 221 either had no follow up or were referred to their general practitioner; this represents 40% of the total number of patients arriving after a 999 call. There was a generally higher proportion of these patients in the younger age groups (11-20 and 21-30), which probably reflected the increased incidence of assaults and excess alcohol consumption in younger adults.

Accident and emergency and ambulance staff tend to think that many 999 calls are inappropriate and that many patients using the service could either wait to see their general practitioner or use other modes of transport to reach the accident and emergency department, and the results of this survey agree with this. The results also broadly reflect those of previous work: in 1980 Morris and Cross found that 51.7% of 999 calls to the emergency ambulance service resulted in an unnecessary journey.² Pennycook *et al* reported in

Deaths from all causes and deaths from ischaemic heart disease during winters (quarters 4 and 1) and summers (quarters 2 and 3), Scotland, 1989-90 to 1993-4

Year	Deaths (all causes)			Deaths from ischaemic heart disease (ICD 410-414)		
	Winter (Oct-Mar)	Summer (Apr/Sep)	Winter excess	Winter (Oct-Mar)	Summer (Apr-Sep)	Winter excess
1980-90	36 224	28 842	7382	9518	8030	1488
1990-1	32 030	28 705	3325	8947	7738	1209
1991-2	32 569	28 692	3877	9031	7703	1328
1992-3	32 493	29 572	2921	8854	7846	1008
1993-4	33 965	28 271	5694	8706	7213	1493

Source: Table 1.2 of *Annual Report of the Registrar General, Scotland, 1994*, and registrar general for Scotland's quarterly statistics.