Heart failure in a DGH

Sir—The article by Parameshwar and colleagues (April 1992, pages 139–142) on heart failure in a district general hospital points out once again the serious nature of this common condition [1,2]. Atrial fibrillation was found in 48 of 140 (34%) of their patients. The authors thus concluded that atrial fibrillation was an important factor in precipitating an acute exacerbation of chronic heart failure. Although atrial fibrillation with rapid ventricular response per se may precipitate heart failure [3,4], this sequence is uncommon. It is more likely that atrial fibrillation was the consequence, rather than the cause, of congestive heart failure in their patients.

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In pursuit of a dubious principle

Sir—Sir Douglas Black's comments, both in respect of the dependent elderly (October 1992, pages 451–2) and in the specific case of euthanasia (page 457) are surely sensible. Furthermore, like Sir Douglas, we instinctively dislike the sneak or tale bearer. Nevertheless, 'a high view of medicine and nursing' should not sanction practices that depend on secrecy for their perpetration. This would be dubious enough in cases of inadvertent negligence or genuine mistake. It cannot be justified when the action taken is both deliberate and adjudged to be criminal. A political party may close ranks and attempt to cover up uncomfortable facts or events—a statement which reflects my 'low view' of party politics.

D. E. B. Powell
Chairman, Mid Glamorgan Ethics Committee

Sir—I was surprised to read Sir Douglas Black's letter (October 1992, pages 457–8). Like him I also would like to see a change in the law regarding euthanasia. He clearly believes that the action of Dr Cox was illegal according to current law and yet objects to that illegality being reported because it involves a dubious principle and causes misery to a colleague. Would he also keep quiet if a patient was injected by accident with the wrong drug and died as a result of it? Would he fail to report to the coroner a case where possible suspicious circumstances had caused the death? Both situations will cause misery to colleagues but maybe the principles are less dubious.

His reason for not wanting to move to legalised euthanasia is because of its 'attendant risks of abuse'. I would suggest that the deliberate concealing of illegal acts, is likely to lead to far more abuse of patients and harm to the medical profession. Sir Douglas, I hope I misunderstand you.

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The MD thesis in the training of a consultant physician

Sir—I was interested to read the above article (October 1992, pages 380–2) and I would agree that an MD may not help to judge the suitability of a junior doctor to become a consultant physician; that is not really its purpose. The MRCP is supposed to have that function. My understanding of the purpose of doing an MD is that it gives the individual insight into the practical difficulties involved in advancing knowledge and inculcates a critical approach to the evaluation of new developments whether scientific, technical or clinical. It gives junior doctors in training, morover, a break in which to think about their interests and futures whilst doing a research project and it is surely, overall, a valuable educational opportunity.

I think most appointment committees indeed look at it in this way. We have many consultants appointed who do not have an MD, even academics, and it is clear that academic capacity and potential can be assessed without one. It might even be argued that it is more important to demonstrate that one has taken time to be critical and thoughtful and painstaking in the evaluation of a project if one is not going to be academic than if one is; though I say this rather as a devil's advocate.

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Sir—My views about the value of an MD are as ambivalent as some of those expressed in the recent article by Harvey *et al* (October 1992, pages 380–2). However, their study did not, in fact, test one of the postulated advantages. They should have looked at *applicants* for the consultant posts featured in the study in order to determine what proportions of successful and unsuccessful candidates had, or were writing up, an MD. When broken down into 'teaching' and 'non-teaching' hospitals such data might truly have reflected the