

The Brown Kelly-Paterson syndrome

Sir—The brief article on the historical debate of the Brown Kelly-Paterson syndrome (July 1991) is interesting and convincing as to its conclusion. However, with respect to historical veracity I think it unfortunate that Slater refers to the publication of Firkin and Whitworth (his reference 6) as 'British'. As both Firkin and Whitworth are Australians is it not a little anachronistic to use the label British to identify two medical practitioners whose peers would see them as practising in Australia, not Britain?

KEITH POWELL

*Senior Physician, Alcohol and Drug Service,
Royal Canberra Hospital South, Australia*

Census of medical registrars

Sir—Dr Hopkins describes (July 1991) the census of medical registrars undertaken by the College in 1990 and the attempts by both the College and JPAC to calculate the requirement for career registrars in the future. The calculations depend crucially on an estimate of the 'wastage' or 'transfer' figure out of the grade: the College give 50%, JPAC 20%. The College figure is based on data on doctors qualifying in 1974 who had at some time been medical registrars but who transferred to general practice or non-medical specialties. It may be that those doctors deliberately sought a medical registrar post to broaden their experience before entering their chosen specialty. Equally they may have determined on a medical specialty but, finding after a number of unhappy and frustrating years that their career pathway was blocked, were forced to leave. Until we know more about the initial aspirations of entrants into the grade and the reasons why they leave, no one will be able to plan accurately for the future.

J. B. COOKSON

Clinical Tutor, Glenfield General Hospital, Leicester

Guidelines on palliative care

Sir—I turned with anticipation to the College working group guidelines on palliative care (October 1991). The report was detailed and I appreciated the efforts of all the working party in its production. It should provide a useful basis for audit.

I was disappointed by a sense of isolation of the palliative care unit from the community. Admittedly the guidelines apply to a hospital type unit, but I found no comments relating directly to general practitioner, district nurse or other community liaison.

May I suggest some additional points to cover in the audit.

Under 'Communication between professionals' No. 17, 'Has the GP been telephoned on death or dis-

charge?' would seem an appropriate addition to ensure prompt continuing care or bereavement visits.

Under 'Final discharge or death summary' No. 21, 'Has a copy been sent to the GP?' could be added.

Finally under 'Record of the reason for admission' No. 3, I suggest adding: 'Have the patients' and the referring doctors' reasons for admission been stated separately if they differ?' and 'Were all objectives met?'.

I hope these comments are of help.

M. RICKENBACH
GP Trainee, Portsmouth

Reference systems

Sir—The name (year) system for quoting references in the text, which Sir Douglas Black (October 1991) prefers to the Vancouver system, has especial advantages for theses because examiners can more easily see from the text whether their own papers have been quoted. But why does he call it the Oxford system? Most users refer to it as the Harvard system (see Baron DN, ed. *Units, symbols and abbreviations*, 4th edn. London: Royal Society of Medicine Services, 1988:52), though I do not know—can any reader tell us?—why that name is used.

D. N. BARON

Beethoven

Sir—Myths relating to the poor health of Mozart in his final years are debunked in the previous issue (October 1991) which also contains an article on the changing presentation of neurosyphilis. In the light of these, and with the bicentenary of Mozart's death drawn to a close, an opportunity now exists to shift attention to Beethoven and lay to rest the notion that his many illnesses were from syphilis.

Although most fascination has centred on Beethoven's wretched, progressive hearing loss which was first mentioned in 1801 when it had troubled him for about five years, the history is one of inexorably progressive multi-system disease. After childhood smallpox and family contacts with tuberculosis, the main features included repeated bouts of depression, recurrent infections, chest symptoms, 'asthma', rheumatism and 'kolik'—diarrhoea with abdominal pain, sometimes prostrating; jaundice occurred at the age of 50, eye pains at 53, dropsy with ascites in the final year, and death occurred in 1827 from liver failure and sepsis. Rheumatic symptoms were notable, particularly during the last decade when there were references to many attacks of 'rheumatism', 'gout' and back pain. At post-mortem the wasted body of Beethoven, covered in petechiae, revealed atrophied eighth nerves, auditory arteries dilated to 'more than a crow's quill', facial nerve enlargement, skull vault