

letters to the editor

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Consultation skills training for specialist trainees (1)

Editor – I was pleased to see a further contribution to research into attitudes about workplace-based assessment. Sandhu *et al* (*Clin Med* February 2010 pp 8–12) obtained the views of consultant and trainee rheumatologists concerning the mini-Clinical Evaluation Exercise (mini-CEX) and some related issues. Their results echo those of previous studies, indicating that trainees value the assessment for its formative potential (but do not always feel that the feedback process is optimal) and that time factors are perceived by all parties as a major barrier.^{1–4}

Sandhu *et al* also consider video recording. Interestingly, in my own study, only two out of 138 respondents suggested videotaping consultations or surgical procedures.⁴ Though this issue was not the primary focus, this suggests that the idea does not carry overwhelming enthusiasm among dermatology trainees. Sandhu *et al* conclude that the method has potential but that it carries certain challenges. The obvious benefit is that trainers can review the recording when not time pressured. The trainee would no longer have to coordinate a time for the consultation with their consultant (but they would still have to meet for feedback). Reliability of the assessment can be improved by having more than one assessor, rarely an option in mini-CEX. However, disadvantages may go deeper than the logistical problems of acquiring, setting up and using the recording and playback equipment. As with direct observation, validity might still be reduced by the 'audience effect': both trainees and patients could be influenced by an awareness of being recorded.⁵ Patient preferences are likely to restrict the selection of consultations available to be recorded.⁶ For example, patients who are embarrassed

by their medical problem seem more likely to refuse to be recorded, though this type of potentially difficult consultation may be of most use in assessing the trainee. The loss of such cases may impact on the validity of the assessment. Patients who, despite misgivings, agree to be recorded may avoid full discussion of their problems, leading to a detrimental impact on their quality of care.⁶ Sandhu *et al* mention the issue of consenting patients for recording, which leads to a further drain on time.

It seems likely that workplace-based assessment by direct observation is here to stay. It is incumbent on both trainers and trainees to make the process as smooth and constructive as possible. Trainers must become adequately skilled in giving feedback.

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Consultation skills training for specialist trainees (2)

Editor – The study on attitudes and perceptions of rheumatologists regarding consultation skills raised important points (*Clin Med* February 2010 pp 8–12). Standardised approaches to assessment would help maintain both trainee and trainer acceptability and reliability. However, this must require training from both sides. Thus, it would be interesting to note if a larger survey would still show all consultants feeling confident to provide feedback irrespective of levels of formal training in consultation skills.

Videotaped consultations can sometimes be just as intimidating as directly observed consultations.¹ They do, however, provide opportunities for self-observation and re-evaluation in cases of controversial feedback. Using several consultations for assessments and opportunities to view simulated consultations for training purposes can help increase trainee confidence and reduce apprehension.² I agree, however, that there is still a need for directly observed training as consultation skills are developed in various settings including ward areas where videotaping may be more difficult.

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Acute heart failure

Editor – We are writing to express our concern at a misconception alluded to by Cleland, Yassin and Khadjooi (*Clin Med* February 2010 pp 59–64). The authors state that ‘patients with acute cardiogenic pulmonary oedema cannot lie flat so, unless the patient is ventilated, myocardial infarction (MI) should be managed with thrombolysis, and unstable angina with judicious doses of nitrates’.

This is outdated advice. Primary percutaneous coronary intervention can be carried out in patients with pulmonary oedema or cardiogenic shock – this is precisely the treatment they need to give them the best chance of survival, and it would be wrong to deny them this because of a misunderstanding of what is technically possible.

It is perfectly feasible to perform angioplasty in the semi-recumbent position, especially if via the radial route, in patients with acute pulmonary oedema and even in those requiring non-invasive ventilation. Clearly it is more technically difficult than performing angioplasty in a supine stable elective patient and angiographic projections need to be modified. The X-ray image intensifier or flat detector is positioned caudally to obtain an anteroposterior cardiac image, and it may be difficult to obtain true caudal views of the heart (as the X-ray equipment cannot be positioned yet more caudally to acquire true caudal views). However, an experienced interventional cardiologist would not shy away from this challenge. These high risk patients have most to gain from primary angioplasty and they should be offered this rather than thrombolysis, which is now regarded as a ‘second best’ treatment for acute MI.

There is much useful information in Cleland *et al*’s article, however this misconception required clarification.

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Care closer to home – a changing role for physicians

Editor – I read Linda Patterson’s editorial (*Clin Med* February 2010 pp 4–5) with great interest. I am pleased to see that general practitioners with a special interest (GPwSI) did receive a mention albeit a brief one.

There are several experienced GPwSIs working in my locality in the field of gastroenterology and endoscopy. In my view both hospital trusts and primary care trusts (PCTs) have failed to utilise this workforce effectively: they have, in effect, been regarded as ‘just another pair of hands’.

The government policy to deliver services closer to the patient’s home is to be welcomed. There is now a new opportunity for PCTs to revisit service design which should permit GPwSIs (perhaps with nurse practitioners) to deliver clinical services from community premises. This would free up time for consultants to deal with bowel cancer screening as well as more complex and difficult cases. However, it is vital that GPwSIs liaise closely with consultant colleagues to ensure that the service design is sound and that the patient journey is appropriate and, above all, safe. Other issues such as training and governance need addressing carefully. The new GPwSI job description in endoscopy together with ongoing appraisal and revalidation (which is currently being developed) will look after this.

The new challenge therefore is not to deliver more of the same locally but to re-examine service design and use the available workforce more effectively. In doing so clinicians will work better together and their patients ultimately will get a better and timelier service.

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Care closer to home is not what the NHS needs

Editor – Linda Patterson’s editorial claims that ‘More community working should lead to better management of chronic disease. This is the future’ (*Clin Med* February 2010 pp 4–5). I hope not. I think it is regrettable

that the ‘care closer to home’ mantra has somehow hypnotised us into presupposing the existence of some physical (or maybe metaphysical) barrier between hospital and community, with prejudices reinforced by inflammatory language.¹ Policy it may be, but if it is bad policy we should have nothing to do with it.

At a time of economic crisis in the NHS we must husband resources. Small shops, while convenient for their users, are inefficient, as supermarket analysis proves. The network of community hospitals that sustained the NHS until the 1980s was largely closed down because it was unaffordable. To recreate it with new community hospitals or polysystems at huge capital cost (not least if projects require large private finance initiative repayments) is madness. What may be more convenient for some service users may be less convenient for others, as became apparent with a proposed network of musculoskeletal independent treatment centres in northwest England.² The idiocy of the approach is exemplified by one of my patients who, told by their general practitioner (GP) that the community service was more convenient (because it was in the community), pointed out that it was two bus rides away when the district hospital was within five minutes’ walk. If patients have to travel to another general practice where the specialist does clinics what difference is it to travelling to the hospital? Except in widely dispersed rural districts there is none. Gains to patients of local access to specialists may be largely offset by the inconvenience of multiple appointments because investigations such as X-rays cannot be organised ‘in the community’ on a one-stop basis.

We have become so focused on the public getting what they think they want that we have forgotten the needs of services and those who work in them. Why should I waste an hour a day travelling between under-resourced sites, thus reducing the number of patients I can see? I did outreach clinics in GP surgeries in the 1980s and abandoned them because they did not work. How will my multidisciplinary teams accompany me without a team bus? What about my inpatients and those I will not be able to see for my colleagues as I am no longer on the hospital site? How will I discuss cases with others, and they with me? If

I am speeding around the community doing rheumatology clinics, how can I manage my rehabilitation unit? Multi-tasking is possible on one site, but not on many. Trainee teaching will collapse as the diversity of case-mix, a virtue of service concentration, will be lost. The opportunity to collect cases for clinical trials will dissipate. Departmental morale will collapse. A two-tier service of superspecialist care in big teaching centres and barefoot specialist care elsewhere will develop. These are not my arguments alone; I asked my chronic disease 'focus group' (our local National Rheumatoid Arthritis Society network group) whether they would prefer to be seen by me in the hospital clinic or in their own GP surgeries. Without exception they expressed a preference to be seen at the hospital, citing many of the above concerns. Ask the wrong people and you get the wrong answer.

Concentration brings benefits. The clearest example of this is surgical; in the first world war facial injury care for Great Britain and the Dominions was concentrated in one hospital (mine, as it happens) and the advances in plastic surgery thereby generated were unmatched on the continent where facial injury was dealt with in a fragmented way. Furthermore the patient support that grew from this obviated the need for a self-help group, whereas in France 'les gueules cassées' developed because of the isolation and dispersion of sufferers.³ To create a specialist diaspora will recreate the disadvantages of dilution. We must learn from history.

Lastly, Care in the Community often means very little, or no, care. As social service budgets contract and input from carers diminishes we have already seen the adverse effects and must do everything we can to avoid this in medicine.

That is not to say that hospital-based care is cheap or that we should not look for ways of making it cheaper, for example by running telephone clinics for those on long-term follow-up. As Patterson points out, hospitals are encouraged to maximise income, while PCTs try to limit access because Payment by Results (PbR) tariffs are unaffordable. But we do not need to disperse specialists to address this; as the musculoskeletal services in Stoke and Bolton have shown it may be possible to avoid sub-

stantial transactional costs by changing management from acute trust to PCT without necessarily altering the physical structure of the service. We should also remember that those services turning a profit in an acute trust (rheumatology outpatients is one) will prop up the loss leaders (acute medicine is one). So pulling out profitable services may compromise the whole of acute hospital-based care – unless the purchaser-provider split is abolished, which, for me, would be the essential and final outcome of Teams without Walls.⁴

I firmly believe that care closer to home is a concept based on flawed research and the turning of a blind eye to economic reality. Specialist medicine as a whole will be seriously damaged if we fail to examine its risks.

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Conflict of interest

AB is employed by an acute trust.

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In response to both

I agree with Dr Cohen that general practitioners (GPs) with a special interest have an important role. It is essential that they feel part of the specialist service and participate in audit, continuing professional development and so on with specialist colleagues.

They also need to be able to discuss patients easily with consultants and to access more specialist opinion when needed, as well as bringing their expertise as to how patients can be managed in the community.

Dr Cohen also makes the point that the challenge is not to deliver more of the same just in a different location – which very well answers Dr Bamji's concerns. Moving expertise into the community, working more closely with GP colleagues, community nurses and other professionals to deliver consultant input in a different way is not just an argument about geography. There are undoubtedly logistical difficulties in providing services in different places, but these can be overcome (and many consultants already deliver outpatient services in locations away from their home base). The point of consultants working in community settings is to develop better pathways of care which are more joined up across the old primary–secondary care boundaries and to truly build Teams without Walls.

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Managing capacity and demand across the patient journey

Editor – Walley and colleagues recently highlighted the problem of reduced bed capacity which has an impact on coping with healthcare demand (*Clin Med* February 2010 pp 13–5).

I would like to comment on the long-term planning and that bed requirements are based on average demand and average length of stay, the author felt that this can create a problem as once there is random variation in demand and staff capacity, bed shortages will occur. I do not feel that we have a bed shortage in England. However, the discharge process is patchy and lengthy and there is a lack of coordination between hospital staff or secondary care and primary care as well as between NHS and social services.

I agree with the author that a 'systems' approach is the only solution where healthcare staff and social services, primary and

secondary care work collaboratively. We may need a unified bed management team in every primary care trust which can allocate the patient after initial assessment to an acute hospital, a community hospital or to intermediate care. This requires training and commitments from all staff. The whole health and social care system should plan together how to meet the demand of the increasing elderly population. I should also emphasise the importance of multidisciplinary teams in each trust for effective discharge planning.

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'With a pinch of salt' revisited

Editor – I read with interest but some concern the recent lesson of the month by Gangopadhyay *et al* (*Clin Med* February 2010 pp 86–7). The lesson highlights a case of severe hyponatraemia which the authors attribute to excessive sweating, poor fluid consumption and low salt intake in a hot environment. There is little evidence to suggest that low salt intake would contribute to this event and the authors have not explored alternative likely explanations. During evolution mankind has survived with very little salt in the diet. Even in modern times, this evidence is detectable in the Yanomano and Xingu Indians living in the humid and hot environment of the Amazon jungle.¹ Their average salt intake, when measured by 24-hour urine collections, varies between 1 and 10 mmol/day. These levels of salt intake, however, are almost unseen in the western world due to the high salt intake we are exposed to, even when adhering to a low salt diet. Under conditions of exercise in a hot environment, a low salt intake does not impair the ability to exercise, and it does not cause changes in plasma sodium, potassium, osmolality or sweat rate, although the salt content of sweat is reduced on a low salt diet.² They misquote the evidence in athletes and the military where the high morbidity from hyponatraemia is due to overhydration (ie too much water) rather than a low salt intake. The case presented here is clearly a case of diuretic abuse, surreptitious vomiting or laxative abuse, as we described in the

past in a different scenario.³ While hyponatraemia may possibly have been caused by water intoxication, it would not have caused plasma potassium to fall so low, or the renin–angiotensin system to be so stimulated. The authors do not seem to have considered screening for diuretics. Diuretic abuse would explain hyponatraemia, alkalotic hypokalaemia, and activation of the renin–angiotensin–aldosterone system as described here. A moderate reduction in salt intake (up to 3 g per day) does not raise cause for concern and should be recommended to everyone to prevent cardiovascular disease and other common conditions like kidney stones and osteoporosis.⁴

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Serum sodium disorders: safe management

Editor – I suspect that Wakil and Atkin were set an impossible task, in reviewing the aetiology, assessment and acute management of hyponatraemia and hypernatraemia in three pages (*Clin Med* February pp 79–82)! The 2007 American guidelines on hyponatraemia alone run to 21 pages, including 120 references.¹ However, the authors of the CME acute medicine review covered this complex topic in a readily accessible manner, for which they should be commended. However, I fear that a number of important and clinically relevant points were not highlighted due to space limitations. Firstly, the contribution of excessive

water intake to hyponatraemia should be stressed. Although classically presented as a psychiatric condition of psychogenic polydipsia, water intoxication is an important differential diagnosis for hyponatraemia. It can also cause a diagnostic challenge and contributes to many cases of hyponatraemia. This was evident in the lesson of the month, published in the same edition of *Clinical Medicine*, where a young man presented with hypovolaemic hyponatraemia.² Secondly, it should be stressed that in older patients with low serum sodium levels, there are often multiple contributing factors. Diuretic therapy may promote hypovolaemia; co-morbidities such as chronic kidney disease or heart failure cause a tendency to hypervolaemia. At the same time, underlying diseases or other medicines such as tricyclic or selective serotonin-reuptake inhibitor antidepressants may cause inappropriate antidiuretic hormone (ADH) secretion. However, the authors' advice that, where there is doubt, isotonic saline should be given is probably valid; but the response to this therapy may be unpredictable. Finally, I worry that the review lacked sufficient detail on pharmacological therapy, advocating the use of new aquaretic drugs but without mention of demeclocycline, which is still commonly prescribed. However, I would strongly counsel against the use of such agents in the acute setting and only where there is a clear diagnosis (with an underlying cause for) inappropriate ADH secretion.

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In response

We thank Aspray for the comment on our article. In answering the first point we

appreciate that polydipsia is a recognised cause of hyponatraemia. However, isolated polydipsia without renal mishandling of water excretion (mainly due to syndrome of inappropriate antidiuretic hormone hypersecretion (SIADH)) is not widely seen in clinical practice. The case illustrated in Gangopadhyay *et al*'s lesson of the month is an example of multifactorial hyponatraemia as the patient had been sweating and was likely to have had primarily volume depletion which contributed to continued antidiuretic hormone (ADH) secretion (urine osmolality was above 100 mosm/kg).¹ Coupled with salt-free water intake, salt loss through sweating contributed to the hyponatraemia in the case described.

Regarding the multifactorial cause of hyponatraemia, we fully agree that the majority of cases of the condition seen in the elderly would have multiple underlying factors. Due to limited space, the review focused on the safe management of hyponatraemia. We think using an algorithm that classifies hyponatraemia into separate aetiological categories and, accordingly, management strategies would aid in the safe management of a very complex electrolyte abnormality. Finally, regarding the use of demeclocycline in the treatment of SIADH, we merely wanted to draw attention to the availability of new vasopressin receptor antagonists which are less nephrotoxic than demeclocycline, if their use was deemed to

be necessary after a diagnosis is reached. However, we do concur that they should not be used in the acute setting.

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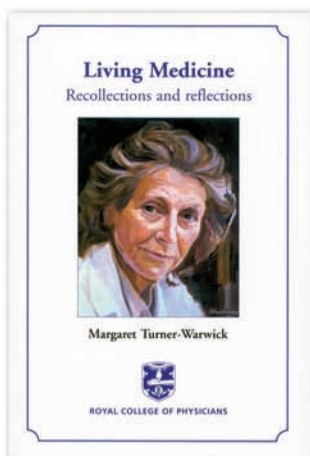
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RCP BOOKS

Living medicine: recollections and reflections

by Dame Margaret Turner-Warwick DBE DM FRCP



The medical career of Margaret Turner-Warwick, first woman president of the Royal College of Physicians, began in the earliest days of the NHS. She is therefore able to present a unique perspective on the development of the health service and on medical practice during the past 50 years – as a medical student at Oxford in wartime, through training and consultant posts, to Professor of Medicine and Dean at the Cardiothoracic Institute – and finally to her Presidency of the College and Chair of a new hospital trust during the market-orientated reforms of the 1990s.

In this fascinating account of her long career – which is firmly set in the context of family life – Dame Margaret Turner-Warwick draws on her experiences to discuss the major issues affecting medicine and healthcare today: how to provide integrated care for patients in the NHS, methods of training medical students and junior doctors, threats to professionalism, the complex and changing relationship between doctors, managers and government, the problems facing tertiary care and clinical research, and how successive organisational changes have actually affected patient care.

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