letters to the editor

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by email to: Clinicalmedicine@rcplondon.ac.uk

The Daniel Turnberg Middle East Travel Fellowship Scheme: cooperation in place of conflict

There are many reasons to be gloomy about the continuing conflicts in the Middle East. The media are replete with reports of terror and destruction and continue to focuse on the animosity between Arab nations and Israel with little regard paid to the many positive but unreported interactions at the Israeli and Palestinian grassroots. In assessing the impact of the Daniel Turnberg Fellowship Scheme we have been encouraged by the many heartening stories of collaboration and reconciliation.

The fund was set up in the name of our late son who was killed in a plane crash in Malawi in June 2007. The scheme reflects his keen interests in research – he was a lecturer in renal medicine – and in promoting better relations between the Middle East, Israel and the UK. It aims to encourage interactions between the UK and Israel and its Arab neighbours in the medical sciences with the longer-term goal of increasing mutual understanding and tolerance (*Clin Med* August 2009 p 304).

After thorough scientific review, 20 fellows were selected to spend up to four weeks in institutions of their choosing to learn new techniques, gain further experience and develop plans for continuing collaboration. The Royal College of Physicians was a generous finder of no less than six of these. Those coming to the UK included seven from Israel, five from the West Bank, two from each of Egypt and Jordan and one from Lebanon with three from the UK going to the Middle East, two to Israel and one to East Jerusalem.

In meeting many of the fellows we were made aware of their high level of enthusiasm and of their appreciation of the opportunity provided by the scheme. Without exception they have developed programmes for continued collaborative research on their return home.

Their individual stories are uplifting. An Egyptian doctor had never been out of her home country before and was overwhelmed by her reception. She has now set up a joint project with her host department in London. A Palestinian researcher has forged several links with researchers in London and an Israeli now has a strong joint project with his host department and is working on a proposal with a Jordanian researcher he met here. A fellow at the Weizmann Institute in Israel has planned a number of joint research activities with neuroscientists in Edinburgh. New friendships have been fostered and, for example, some supervising UK hosts are now planning visits to the Middle East and Israel, countries where they have not previously been. Such outcomes can only increase understanding and respect.

We met some of our fellows in their own institutions when we visited Israel recently to learn more about their work. Two paediatric hospitals were particularly interesting because of the positive role they are playing in caring for Palestinian children. We learnt that in the Safra Children's Hospital at Tel Hashomer, near Tel Aviv, at any one time there are 30 to 40 children from Gaza with their families receiving specialised care such as cardiac surgery or bone marrow transplantation. More than half of their cardiac surgery patients are from Gaza. A similar story is told at the Schneider Children's Hospital where we saw many Palestinian children being cared for and where a paediatrician from Gaza spent 18 months training in paediatric oncology.

One story of particular poignancy was that of Dr Izzeldin Abuelaish, a Gazan paediatrician, three of whose children were tragically killed in the conflict when a bomb fell on his home. Another daughter and his niece who were badly injured were airlifted out and treated in the intensive care unit at Safra Children's Hospital. Fortunately they each recovered and returned home. In a remarkable story of reconciliation, Dr Abuelaish placed a memorial plaque to his three children, together with a photograph of them, in the hallway of Safra Hospital to which he continues to refer patients.

There are many such interactions but they remain largely unpublicised, in part at least because of the fear that Hamas will clamp down on them. But these incidents cast a different and more hopeful light on the complex issues surrounding the Middle East and they have made us even more determined to continue with our scheme.

The panel for the next round was set up by the Academy of Medical Sciences (for further details and an application form: www.acmedsci.ac.uk/p175.html) and will meet to assess the applications in March 2010. We are hopeful that we will be able to support rather more than 20 fellows in 2010. We hope that schemes such as ours, that promote collaboration, will play a role in contributing to a greater understanding and mutual respect.

LESLIE TURNBERG
Former president
Royal College of Physicians

The value of the post-take ward round

Editor – Chaponda and colleagues recently highlighted the impact of shift working on patient care continuity and learning opportunities for acute medicine trainees (*Clin*

Med August 2009 pp 323–6). One of the (perhaps) unexpected results they included in their table (but did not discuss), was the significant reduction in specialist registrar (SpR) diagnosis differences from the clerking diagnosis (from 35.8% in 2006 down to 24.3% in 2008, odds ratio 0.58 (0.40–0.83), p=0.002).

It would be interesting to know how this result is accounted for by the authors. Three possibilities come to mind. Firstly (the most favourable interpretation), an improvement in the diagnosis formulation skills of junior doctors in 2008; secondly (a less desirable scenario), a significant increase in actual SpR clerkings reflecting changes in working patterns between 2006 and 2008 and a shortfall of capacity in clerking junior doctors (ie below SpR grade); and thirdly (the least favourable scenario), a decrease in quality of the diagnosis formulation skills of SpRs in 2008 reflecting possibe changes due to working patterns.

The fact that there was no change in the difference between consultant diagnosis and SpR/junior doctor diagnoses in 2008 would not support the third or first scenarios and suggests no decrease (or improvement) in the diagnosis formulation skills of both junior doctors and SpRs over the time of the study. The reduction in SpR only reviews is, however, consistent with the second scenario of increased SPR clerkings. This may merit further analysis as, if confirmed, it will have implications for SpR training in the longer term. It is clearly important that SpRs have the opportunity to review a significant number of cases clerked by their junior colleagues as part of their own professional development and training.

ANDREW MEDFORD
Interventional pulmonology fellow
Glenfield Hospital, Leicester

In response

We are pleased to respond to comments about our audit of educational aspects of post-take ward rounds (PTWR) in 2006 and 2008.

We voiced our concern that, in both audit years, the case notes of about half the patients contained no indication that results of investigations had been reviewed before the PTWR. Kendall *et al* (*Clin Med* December 2009 pp 544–8) commend the educational value of a structured consultant-led patient handover which might encourage the timely review of results, but this would still need to be recorded in the case notes. We suspect that the latter is most likely to occur during the PTWR.

In this issue, Medford noted the small drop in the proportion of diagnoses that were changed after specialist registrar (SpR) review of patient clerkings performed by more junior trainees, with no change in the number of diagnoses altered at consultant review (about 25% in each year). He wondered if the apparent reduction of changes in diagnoses made by SpRs was due to improving diagnostic skills of the junior trainees, or to a greater proportion of patients being clerked by SpRs. We found that, in 2008, 44.3% of patients were reviewed by both a consultant and an SpR, 45.4% by a consultant alone and 6.8% by an SpR alone, compared to 48.2%, 24.7% and 26.2% respectively in 2006. This does not directly answer the question, but suggests that there were fewer opportunities for SpRs either to review or to clerk patients themselves in 2008. We agree with Medford that the arrangement of medical on-call and PTWR should allow middle and senior grade trainees adequate opportunities to supervise more junior colleagues and to formulate their own diagnostic and management plans, followed by discussion with consultants. The challenge is to enable this to happen as near in time and place to the patient as possible during the patient admission process, so that the patient benefits from early senior review and trainees benefit from review of their diagnostic, therapeutic and management decisions.

Kendall *et al* state that '… this may require a paradigm shift in consultant working practices'. More simply, we need to rearrange work shifts and timings of PTWR in our trust so that trainees can attend more rounds at which patients they have just seen are discussed, and we are working on this and incorporating other suggestions such as those above.

NJ BEECHING
Consultant physician
M CHAPONDA
Specialist registrar
DS ALMOND
Consultant physician
M TAEGTMEYER
Consultant physician
Royal Liverpool University Hospital

Timely diagnosis of convulsive syncope can avert imminent death

Editor – Timely diagnosis of convulsive syncope is crucial to the correct management of underlying causes such as implantable defibrillator malfunction,[1] long QT syndrome,[2] and Brugada syndrome,[3] which may present with self-limiting ventricular tachyarrhythmia.[1–3] Timely identification of convulsive syncope becomes a diagnosis of immediate life-saving importance when ventricular tachyarrhythmia is no longer self-limiting, and the window of opportunity for successful defibrillation is narrow and finite, as was the case in 50% of 14 young athletes aged 14–17, in whom potentially irreversible exercise-related 'collapse' was associated with convulsive syncope.[4] In the same study, similar brief seizure-like activity was noted in 13% of 22 older persons aged 42–71 who collapsed within range of defibrillators installed on that high school campus.4 One of the conclusions from that study was that, in young athletes 'brief myoclonic activity after collapse… could be mistaken for a seizure', especially if rescuers mistook agonal or occasional gasping for normal breathing, and if they falsely identified the presence of a pulse.[4] Accordingly, the opportunity to make a rapid life-saving diagnosis can only be optimised by heightened awareness of the entity of convulsive syncope even where ventricular tachyarrhythmia might not be self-limiting and by heightened awareness that rescuers may fail to recognise sudden death as a 'signature' of that subtype of ventricular