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.

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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.

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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

tachyarrhythmia when they misidentify the pulse,[4] or when they mistake agonal gasping for normal breathing.[4,5]

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Improving the process of discharge (1)

Editor – Dainty and Elizabeth's excellent review (*Clin Med* August 2009 pp 311–4) should be read by all professionals dealing with discharge; I shall certainly give it to medical students in our small group tutorials dealing with teamwork. But, while better education is certainly needed, most physicians will recognise organisational problems that thwart the best plans even of those who know what to do.

Discharge planning is a good general marker for the integrity and performance of teams. Before recent retirement from clinical practice I spent a great deal of time trying to improve the ways in which ward teams could work. What gets in the way of good practice? The first problem is, very simply, a lack of proper teams. The word 'teamwork' is on everyone's lips and 'good team player' included in person specifications for jobs but too few understand what it takes to form and maintain an effective team. Even then working and staffing conditions are such that successful teams are difficult to achieve. Disintegration of teams and continuity of care are key problems for discharge but there is often also a problem of engaging with outside agencies. Some still regard hospitals as 'places of safety' for patients and lack incentives to accept patients quickly back into the community when medically appropriate.

Two problems deserve particular mention. The authors rightly state that discharge planning starts at admission. Unfortunately this first step is problematic unless the admitting doctor and nurse sit down together for a few minutes to agree (and document) the nature of the patient's problems and the initial plan. Anyone who has not compared medical and nursing plans for the same patient might be surprised by the amount of incongruity. The excuse is usually that they lack time to work together in this way although a little time spent together initially saves much more time and trouble later. Many hospitals also still lack a reliable way of documenting one agreed discharge plan that follows the patient in time and place and which is used by everyone involved in care and discharge. The resulting confusion increases risk and wastes time.

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Improving the process of discharge (2)

Editor – I was delighted to read Dainty and Elizabeth's paper (*Clin Med* August 2009 pp 311–4).

While I agree that discharge planning should always begin early on in the admission process, practically this is not always possible. There may be detrimental steps when focus on discharge becomes the priority of the admissions unit. Making an accurate comprehensive diagnosis in the context of multiple pathology, delirium and complicated social circumstances takes time. There are always quality of care issues that are as important as length of stay. Inappropriate readmission may be an unfortunate consequence. Without the correct facts about social circumstances and a secure medical diagnosis and for that matter multidisciplinary assessment, you cannot predict length of stay or rehabilitation potential and requirements.

It really does undermine care when all professions focus on 'what can we do to get them out' rather than 'how can we best help this patient'.

There is often a cocktail of chaos and conflicting information by the time a patient reaches a care of the elderly ward. The unpredictable nature of so many of our frail elderly compounds the story. Amid this chaos, informing a family or next of kin about forced untimely discharge will generate complaints and distrust. A typical example would be the very variable length of stay for an elderly lady with fractured neck of femur. Consider all the possible postoperative complications. Multiple bed moves and conflicting and contradictory information from different professionals becomes normality. One says 'nil by mouth' another says 'dysphagic diet'. One ward says rehabilitation is required another says reablement or resource centre care is required. Not only are the family confused most of the junior doctors have little or no understanding of types of community care available in their own town, let alone neighbouring and often differing arrangements for out-of-area patients.

My opinion relating to timely discharge is that it can only be estimated when all the correct facts and medical information are available. And even then in the hands of an experienced physician and geriatrician it is not always easy. The phrase 'fit for medical discharge' is a misnomer. If the patient cannot walk and lives alone requiring a package of care from social services they are not fit for discharge. More accurately they are well enough not to require an acute hospital bed but so frail they cannot be discharged without social support.

I commend this article and timely preparation for discharge in all patients admitted to hospital. What may be lacking is the experience to know, and the honesty to admit at times we just have to wait and see.

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