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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Response to both

When developing our review we were keen to generate discussion with a view to raising awareness of, and improving practice around, discharge planning. We therefore appreciate the comments of Drs Levine and Leung.

We agree that sharing accurate information in a timely manner is a key factor in both discharge planning and provision of high-quality care. The presence on ward rounds of nursing staff should improve this, but can be suboptimal. Combined paperwork and single assessment pathways, alongside daily targeted multidisciplinary meetings have been used in the admission unit at Stafford with some effect. Many other assessment units (eg Wolverhampton) provide active elderly care in-reach services and/or regular consultant input, potentially facilitating more appropriate discharge and admission.

Admissions units are a hub in most acute hospitals, and accurate assessment and decision making, with early senior clinician involvement at the point of admission, can ultimately improve care downstream. We would endorse the points raised by Dr Leung regarding the potential conflict between early discharge and the provision of high-quality care, and the fact that many frail patients with complex medical conditions and social circumstances cannot be discharged directly from admissions units.

Pathways/protocols for early discharge of patients with selected conditions (eg deep vein thrombosis, cellulitis) from admission units have been described.[1,2] We also recognise concerns of colleagues around setting discharge dates, and use the term 'provisional discharge date' in the notes, thus allowing flexibility.

Comprehensive assessment for many patients requires admission to specialist elderly care wards, where time will allow multidisciplinary assessment to occur. Our review aims to improve discharge planning both from admissions areas and specialist wards, improving the flow of patients through hospital, to allow more efficient use of resources.

Regular formal multidisciplinary meetings that document clear plans, proposed timescales, and individual responsibilities (either in clinical notes or on multidisciplinary handover sheets) can advance this process. We have also found that whiteboards are helpful in focusing actions of members of the multidisciplinary team.

Discharging patients, both from admissions unit and elderly care wards, can be a challenging process, and should be actively taught to doctors in training. Unsafe discharges reflect poor care and are unacceptable.

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A postal survey of doctor's attitudes to becoming mentally ill

Editor – I read with great interest Hassan *et al*'s excellent paper (*Clin Med* August 2009 pp 327–32). There is much research and publicity, for example a recent Department of Health review,[1] which finds that there are higher rates of psychological illnesses in doctors than the general population, so it is surprising to find in this study that the majority of doctors, especially psychiatrists, were not aware of this fact. Overall it seems to me that as a profession we are having the same 'conversation' about this issue. The debate on how to provide services for sick doctors has continued in a similar way for years. One of the factors that bothers doctor-patients most, indeed many patients, is the stigma of illness and sickness absence, as is borne out in this study. It is interesting that in reality most doctors do not lose their jobs, or have any long-term problem resulting from the fact of a particular diagnosis or sickness absence. It is true that long-term sickness absence requires a multidisciplinary approach and that the earlier a problem is dealt with the better. Many of a doctor's problems with illness arise from a denial of them. Confidentiality, which is different, and as borne out in this study, is the key to managing these situations. Many services for doctors do exist, can be accessed via their general practitioners or occupational health departments, and can be off-site from the workplaces.

I am surprised that most respondents say they would talk to family and friends because in many cases, in my experience as an occupational physician, once doctors and other people are ill, they find that admitting illness to family is difficult. Those answers smack of denial as well and may be a source of information bias in the study.

Most interesting is that the authors say that these attitudes and perceptions about doctors' health should be tackled and changed at medical school level as I am currently carrying out this kind of work with students. I have found, sadly, that the attitudes written about in this paper are well-entrenched by mid-third-year stage.

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The skin in general medicine

Editor – Dhoat and Rustin reviewed an important but often neglected part of general medicine in their article (*Clin Med*