

Academic health centres: managing the transition from good to great

Editor – The article by Noble *et al* (*Clin Med* February 2010 pp 16–9) describes the high level strategies in four consistently high achieving healthcare organisations in the USA. While the American healthcare system has its flaws, the four organisations in Noble's article are outstanding.

Noble's observation that what unites academic health centres is greater than what divides them is important on this side of the Atlantic. We believe it extends even further: the factors that contribute to greatness apply to NHS acute trusts, where many district general hospitals are larger than academic institutions in the USA.

In contrast with the USA, where organisations such as John Hopkins are able to acquire a national reputation,¹ in the UK we avoid talk of greatness. In *Good to great*, Jim Collins described great companies as organisations with a rigorous attachment to discipline and a relentless focus on key activities that make for success.² Great organisations avoid Collins' definition of mediocrity: that is organisations that characteristically manifest 'not reluctance to change but chronic inconsistency'. The NHS generally suffers from this problem of chronic inconsistency.

Understanding and implementing proven, relevant methodologies as well as having guiding principles and strategies and acting systematically on all fronts in a coordinated fashion is what is required to improve. Focusing on the how and applying it in the UK setting is the challenge.

The King's Fund Point of Care hospital programme, recognising the current state in NHS hospitals, aims to work with a handful of hospitals to test specific, system-wide methodologies designed to transform cultures and improve quality of care, ideally without additional cost.³ Vanderbilt, widely acknowledged in the USA as outstanding in delivering patient-centred care is one of the examples we will be working to emulate.⁴

We recognise that making a commitment to transform quality of care in these hard

pressed times, is high risk. But unless we change our thinking and rigorously apply ourselves to working systematically towards the aim of reliable excellent quality of experiences, we will not break free from mediocrity.

JOANNE WATSON

Clinical director of Hospital Pathway Project

Point of Care Programme

King's Fund, London;

Consultant physician

Musgrove Park Hospital, Taunton

JOCELYN CORNWELL

Director of Point of Care Programme

King's Fund, London

References

- 1 Berry L, Seltman K. *Management lessons for Mayo Clinic*. New York: McGraw Hill, 2008.
- 2 Collin J. *Good to great*. New York: Harper Business, 2001.
- 3 Goodrich J, Cornwell J. *Seeing the person in the patient*. The Point of Care review paper. London: The King's Fund, 2008.
- 4 Shaller D. *High-performing patient and family centered care academic medical centers. Cross-site summary of six case studies*. Camden Maine: Picker Institute, 2009.

Pericardial effusion – forgotten differential diagnosis of shortness of breath

Editor – I read with great interest Nijjer *et al*'s excellent paper (*Clin Med* February 2010 pp 88–90). Delayed pericardial effusion can also be related to primary lung tumours or haematological tumours.¹ In acute medicine, when a patient with known left ventricular dysfunction presents with shortness of breath, the most obvious diagnosis is heart failure. However, I have recently seen a case of a 70-year-old gentleman who was known to have moderate left ventricular systolic dysfunction and atrial fibrillation. He was admitted acutely with symptoms and signs suggestive of decompensated heart failure. His presenting electrocardiogram (ECG) confirmed atrial fibrillation and had poor R-wave progression. He was started on intravenous diuretics and also rate control antiarrhythmic drugs. He responded slightly to

treatment and was also noted to be hypoxic on air. His chest X-ray revealed pulmonary congestion with some right upper lobe consolidation and cardiomegaly. A computed tomography pulmonary angiogram was organised which showed gross pericardial effusion and also a primary lung tumour in the right upper lobe. Retrospective analysis of his serial chest X-ray revealed that his cardiomegaly had worsened markedly in two months.

If this gentleman had a bedside echocardiogram done on his presentation, his diagnosis would have been made immediately and a prompt treatment strategy could have been started. Therefore, it is prudent to consider pericardial effusion in a patient presenting with shortness of breath, globular heart on chest X-ray and poor R-wave progression on ECG, irrespective of past medical history. A suspicion of pericardial effusion should lead to prompt bedside echocardiogram by an echocardiographer or acute physician trained in basic skills of echocardiography.²

PANKAJ GARG

Clinical fellow cardiology

Aintree Cardiac Centre

University Hospital Aintree, Liverpool

References

- 1 Roberts W. Pericardial heart disease: its morphologic features and its causes. *Proc (Bayl Univ Med Cent)* 2005;18:38–55.
- 2 Tsutsui JM, Maciel RR, Costa JM, *et al*. Hand-carried ultrasound performed at bedside in cardiology inpatient setting – a comparative study with comprehensive echocardiography. *J Cardiovasc Ultrasound* 2004;2:24.

A critique of the specialty certificate examinations of the Federation of Royal Colleges of Physicians of the UK

Editor – We welcome John Cookson's interest in our new specialty certificate examinations (SCEs) (*Clin Med* April 2010 pp 141–4). However, his critique was based on a limited selection of the available information, so this correspondence provides a fuller update for readers. Four years on