in the seeking of consent for AS. After Shipman, the media, and perhaps some families, would be all-too-ready to claim that a doctor exerted undue pressure on a patient. Whatever is to be argued for or against AS (and we were neutral on this) there is no logic in calling it a 'health benefit', and if doctors concern themselves with matters other than health benefits they will fall under suspicion.

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Perceptions of heart failure

Editor – I read with interest Banerjee's paper about patients' understanding and perceptions of the diagnosis of heart failure (*Clin Med* Aug 2010 pp 339–43). Much is often made of the poor prognosis of heart failure when compared with various malignancies. However, it is only at the level of prognosis that people seem to draw comparisons. Why?

Patients understand that malignancy is serious and as such patients are aware that treatment is necessary if life is to be prolonged. The same cannot necessarily be said of heart failure patients. In an audit performed in a GP's practice of patients with heart failure managed in primary care, I found that only a third of patients were on maximum tolerated doses of ace inhibitor and betablocker, ie being treated as aggressively as possible. It is hard to imagine only a third of cancer sufferers getting full doses of chemotherapeutic agents. Furthermore, when the rationale for repeated appointments to increase the doses of these medications was explained to patients, every patient attended for further uptitration of their medications.

If we do not tell patients negative prognostic information, then how can we expect them to engage with multiple appointments and blood tests, and comply with new medication regimens which may not make them feel any better in the short term but will offer them advantages in mortality and morbidity?

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The European Working Time Directive and training

Editor – Goddard presented important preliminary findings in his editorial on the impact of the European Working Time Directive on training (*Clin Med* Aug 2010 pp 317–18). However, his conclusion that conversion to a 56-hour working week has not significantly impacted on the quality of training of physicians is unsupported by data. Admittedly, he concedes that the measurement of such impact is difficult due to the lack of validated quality measures of training. While the table he presented may not demonstrate a statistical difference in numbers of procedures performed by trainees between the two periods assessed (1998–2002 and 2003–7), procedural competency in the 'craft medical specialties' is nevertheless influenced by absolute numbers of procedures undertaken. Of the procedures listed in the table, only trainee-performed angiography and echocardiography increased in numbers between the two periods. This may be a cardiology-specific characteristic; indeed, in the same article, Goddard comments on the longer hours that cardiology specialist registrars (SpRs) work in comparison to another specialty. Perhaps something useful may be learned from our cardiology trainers in this regard. With respect to the numbers of bronchoscopies performed pre- and post-2003, while the comparison may not be p-value significant, it is undeniable that a mean difference of over 60 procedures performed by the end of training is likely to be qualitatively significant in distinguishing a skilled and procedurally-confident late-stage SpR or new consultant from a merely competent one.

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In response

I agree with Dr Chua's comments. The data presented were based on a survey of consultants completing their training in the past 10 years and as such were subject to recall bias. Usually, unless detailed records have been kept, individuals over-estimate how many procedures they have done. Since that study we have started an annual survey of trainees obtaining a certificate of completion of training in the previous 12 months. This survey includes collecting procedural numbers during training. Data from the 2009 survey show that numbers have fallen in all the procedures compared with the data I presented. The numbers for colonoscopy, endoscopic retrograde cholangiopancreatography, angiography, echocardiography, chest drains and bronchoscopy were 607, 186, 907, 780, 52 and 68 respectively. These data were not available when I wrote the editorial but certainly give good weight to the concerns many consultants, including myself, have about the quality and quantity of training in a 48-hour week.

ANDREW GODDARD
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Master of Science in medical leadership

Editor – I read with interest the article on the varied academic approaches to medical leadership (*Clin Med* Oct 2010 pp 477–9). I was surprised, however, that the authors failed to include a reference to Kent, Surrey and Sussex deanery's clinical leadership fellowship which is now in its second year and has the advantage that it combines practical management experience for a cohort of registrars in hospital trusts with a work-based masters at Brighton Business School in clinical leadership and healthcare management. There is also the benefit that this is a fully funded/salaried position which none of the other courses appear to be. If the desire is for younger physicians to be involved and experienced in management and lead on transformational change projects then this format perhaps represents

the pre-eminent approach in the field and deserves a mention.

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ERRATUM

Letters to the editor: *Clinical Medicine*, December 2010, pp 637–8

Please note the authors of the letter 'NHS research governance procedures' were Peter Selby, director and John Sitzia, acting chief operating officer from the National Institute for Health Research Clinical Research Network. The title of the next letter should not have the title 'National Institute for Health Research Clinical research Network'

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

A survey of new to follow-up ratios in rheumatology outpatients departments

Practice Based Commissioning (PBC) and Payment by Results (PBR) have introduced perverse incentives for clinicians to work in ways that are not always in the best interests of the patient. PBC may lead to patients who would benefit from a specialist opinion not being referred on cost-saving grounds, or being referred to alternative providers (including private companies) who lack the training and expertise of established specialty multidisciplinary teams. PBR increases income by focusing on new, rather than follow-up, patients (higher tariff earnings for the former compared with the latter) with up to a 13% increase in income if the consultant sees predominantly new patients.[1,2] This has led to some colleagues being asked to lower new to follow-up ratios or having to work to fixed ratios which are usually lower (n = more new, less follow-ups) than those currently being achieved by the unit. Other pressures on new to follow-up ratios include the 18-week pathway and the perception that many follow-up visits are unnecessary and tie up clinical time.

The British Society for Rheumatology (BSR) clinical affairs committee was contacted by a number of colleagues expressing concern about new to follow-up ratios being imposed upon. In order to determine the size of the problem, and whether any recommendations could emerge from this, the committee embarked on a survey to collect data on new to follow-up ratios and whether colleagues had been pressurised to reduce these figures in favour of new patients.

The survey was sent to all consultant rheumatologists both electronically and by post in October 2007 with a reminder sent out in January 2008. It included a diary function in which rheumatologists recorded their clinics and how many new and follow-up patients were seen in each. Only 96 responses were received from a possible 545. The median number of years that consultant respondents had been in post was 10 years (range 0.5–29). The median population served per unit was 330,000 (range 110,000–1,000,000). In total, 93% knew their new to follow-up ratio, which was a median of 3.6:1 (range 1–8). Of respondents, 79.6% were pure rheumatologists without a commitment to another discipline. The median number of consultant-led clinics was four (range 2–7).

The survey asked about annual figures of new and follow-up patients and a new to follow-up ratio (3.3:1) was calculated based on these figures. The reported ratio and the calculated ratio were then compared using linear regression. There was a wide variation with only 30% of the variance in the reported ratio being explained by the calculated ratio. Figure 1 shows that for some colleagues there was a large discrepancy between the new to follow-up ratio that they had reported for their unit and the number calculated for the ratio based on the number of new and follow-up patients listed in the diary. Part of this discrepancy could have been accounted for by differences in practice, and by interpretation of what constituted a follow-up (for example disease-modifying antirheumatic drug (DMARD) monitoring was counted as a follow-up appointment in 24.7% of responses).

Of the respondents, 34.5% had been asked to work to a set new to follow-up ratio. This was a median of 3.1 (range 1.3–4). In total, 17.5% of respondents reported that their unit or hospital would incur a financial penalty if they did not reduce their ratios. These data were presented at the Standards Audit and Guidelines Working Group meeting held at the BSR annual general meeting (AGM) in Liverpool. The data sparked a debate over two main points: