TA15, therefore, recommended zanamavir for the immunocompromised, those over 65, and those with chronic lung disease, significant cardiovascular disease, or diabetes. But it maintained the 'not recommended' conclusion for otherwise healthy adults.

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Reference

1 National Institute for Clinical Excellence. *Guidance on the use of Zanamavir (Relenza) in the treatment of influenza* (TA15). London: NICE, 2000.

Clinical and 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Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section.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.

Factors influencing recruitment to rheumatology

Attracting suitable candidates to rheumatology is vital to maintaining standards of service. We noted that recently there have been relatively low numbers of applications for rheumatology at specialty training year 3 (ST3) level, and so we decided to undertake a study looking at factors affecting career choices, and doctors' attitudes to rheumatology as a specialty. An online questionnaire was developed using Survey Monkey, and emailed to doctors at foundation year (FY) 1, FY2, core medical training (CMT) and basic specialty training (BST) levels working in two trusts within the Eastern region – Norfolk and Norwich University Hospital and Addenbrooke's Hospital, Cambridge.

Key findings were as follows. Junior doctors are making decisions about which specialty to choose early on in their careers. Rheumatology appears to be on the radar, with nearly 70% of respondents having considered, or who are considering, it as a career. However, reduced exposure to rheumatology inpatients, and less junior doctor posts, limits experience gained. It is vital that we take steps (see Box 1 for ideas) to raise the profile of rheumatology and ensure that we continue to attract strong candidates in order to maintain a high standard of care for patients.

Background

Attracting suitable candidates to rheumatology is vital to maintaining standards of service. We noted that recently there have been low numbers of applicants to rheumatology at ST3 level, so decided to undertake a study looking at factors affecting career choices, and doctors' attitudes to the specialty.

Method

An electronic questionnaire was emailed to doctors at FY1, FY2, CMT and BST levels working in two trusts within the Eastern region – Norfolk and Norwich University Hospital and Addenbrooke's Hospital, Cambridge. It focused on three areas; anonymous demographic information, reasons behind career choices and attitudes to rheumatology as a specialty.

Results

Out of 270 doctors, 90 (34%) completed the questionnaire; of these 48% were male and 52% female. At the time they responded, 77% of doctors had decided on the specialty in which they wished to work. Asked at which point in their careers they had made this choice responses were as follows: 10% before entering medical school, 26% during medical school, 36% during FY1, 16% during FY2 and 22% during CMT/BST.

Factors most important when choosing a future career were an interest in the specialty and job satisfaction. Less important were opportunities for flexible/part-time training, favourable working hours and good monetary rewards. Of respondents, 67% said that they were considering/had considered choosing rheumatology. Among those who considered it, reasons for doing so included an interest in the specialty, exposure as a medical student and favourable working hours. A free-text box asked for suggestions to improve recruitment to rheumatology. Qualitative responses were analysed and emergent themes are highlighted in Box 1.

Box 1. How can we improve recruitment to rheumatology? Emergent themes from qualitative responses.

- Increase exposure of medical students
- Increase exposure of junior doctors
- Offer taster weeks
- Research projects/audits in rheumatology
- Sell itself as a speciality at career evenings
- Provide teaching/practical skills sessions
- Offer positive role models

Discussion

This study highlights a number of key points. The majority of doctors have decided on which specialty they wish to choose by the time they enter CMT or BST. They are keen to find an interesting specialty with good job satisfaction, and for many rheumatology is on the radar. However, applications at ST3 level are low compared to many other specialties. This is despite the fact that rheumatology compares favourably with other specialties in terms of job satisfaction.[1]

Administering the survey electronically allowed us to target a large number of doctors. The overall response rate is lower than the mean of 54% seen in other published studies without monetary rewards,[2] perhaps reflecting the electronic method of delivery – often response rates for postal questionnaires are higher than that for electronic communications.[3] Response bias cannot be excluded as a factor which may have influenced the findings, but there were many responses from doctors who had, and had not, considered rheumatology as a career choice.

Junior doctors are making decisions about which specialty to choose early on in their careers. Reduced exposure to rheumatology inpatients, and less junior doctor

posts limit experience gained. It is vital that we take steps (Box 1) to raise the profile of rheumatology and ensure that we continue to attract strong candidates in order to maintain a high standard of care for our patients.

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A review of discharge planning for people with chronic obstructive pulmonary disease at high risk for readmission

The National Institute of Health Research Northwest London Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is an alliance of academic and healthcare organisations working to develop and promote a more efficient and sustainable uptake of innovative and cost-effective interventions into care for patients.[1] Patients who require long-term care for conditions such as chronic obstructive pulmonary disease (COPD) may have differing service needs and are often involved with many healthcare organisations and health professionals.[2] A CLAHRC work stream has focused on the development and roll out of a COPD discharge care bundle in North West London in order to reduce hospital readmissions and improve the patient's quality of life.

To understand the potential benefits that care bundles could confer, we undertook a review of the interventions that reduce readmission to hospital with the aim of informing the CLAHRC COPD bundle initial development. A care bundle being a group of evidence-based interventions that address a particular health issue to prevent further episodes of illness.[3] There is emerging evidence that care bundles may reduce hospital mortality.[3,4]

A comprehensive search for interventions associated with a reduction in COPD readmissions and improved functioning was performed using the following databases, with no limits applied: Medline, Pubmed, PsycINFO, EMBASE, Cochrane Library, CINAHL, Database of Abstracts of Reviews of Effectiveness, and TRIP. Additional searching of conference proceedings and web browsing was undertaken to identify further publications. In total, 714 references were identified after duplicates were removed.

We identified themes of integrated and intermediate care, psychological support, nutritional care and pulmonary rehabilitation, as interventions that reduced readmission and improved functioning. Pulmonary rehabilitation especially had substantial evidence for reducing readmission and improving functioning.

When focusing upon readmission, potential deficits were identified in communication, medical errors, and recognition that some COPD readmissions may not be disease driven but may be due to a psychosocial component and/or social isolation.[5,6] In a Canadian study, adverse events associated with COPD exacerbations were significant in both hospitalised and discharge care programmes.[7] Care gaps were identified in patient education-related medicines, oxygen therapy and poor documentation of the patient progress over time.[7] Furthermore adverse drug events were highest for corticosteroids, anticoagulants, antibiotics, analgesics and cardiovascular medications.[8] The lack of monitoring of these medications by health professionals after hospital discharge was the most common cause of preventable adverse drug events.[8]

In conclusion, there is evidence that in the management of COPD a discharge care bundle for COPD patients could prove beneficial. There are gaps in knowledge requiring further research and considering all readmissions as a failure of care must be undertaken with caution. However, putting into practice that which is already known should have a positive effect upon outcomes.

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