

are used alone or co-administered with conventional drugs. Most herbal products on the market today have not been subjected to the approval process of the US Food and Drugs Association (FDA) and are not regulated for purity and potency. They may contain toxic substances or other contaminants which may increase the possibility of adverse effects.² Hence rigorous scientific methodologies and clinical trials to ensure the quality and consistency of herbal products should be undertaken.

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Learning curves for bronchoscopy and simulation

Editor – Further to Dr Holyoake's comments about virtual bronchoscopy simulation (*Clin Med* April 2013 pp214), I would also support the use of such technology in terms of improving preparation prior to 'hands on' training or to consolidate learning. However, studies are limited on this in the literature and a recent systematic review did show some evidence favouring simulation.¹ It is unsurprising that simulation would be of benefit as studies of the effects of the European Working Time Directive (EWTd) have shown a significant impact on the number of bronchoscopy procedures undertaken by higher specialist trainees (greater than 30% in one study).²

In the field of ultrasound bronchoscopy (used here as a surrogate for conventional bronchoscopy), cumulative summation analysis and other studies have shown that the learning curve is very variable, hard to predict and may be longer than thought, even among experienced bronchoscopists.^{3,4} Simulation is also being trialled here with some initial promise.⁵ Similarly for conventional bronchoscopy, one would expect different rates of learning among novices who have never performed bronchoscopy. Cumulative summation analysis is a good way of documenting rates of procedural learning.

With regard to Dr Holyoake's other comments, it is of course important that simulation reflects real life too. Therefore, the orientation of the simulator should actually encompass both intubation from behind the supine patient (as commonly done in intensive care, interventional and ultrasound bronchoscopy,⁶ and conventional bronchoscopy) and intubation from in front and to the side of a patient lying at 45 degrees (also commonly but not exclusively used for conventional bronchoscopy). As respiratory physicians need to be able to bronchoscope from both positions, learning both is important.

Table 2. Herbal medicines causing moderately severe adverse drug reactions.

Herbal medicine causing serious ADRs	Common names	Common uses
Pelargonium sidoides	Umckaloabo, South African geranium	Respiratory infections, intestinal problems
Perna canaliculus	Green-lipped mussel	Anti-inflammatory remedy
Aloe vera	Aloe	Multipurpose skin treatment
Mentha piperita	Peppermint	Abdominal pain, indigestion, irritable bowel
Medicago sativa	Alfalfa	Diabetes, bladder diseases, anaemia
Cemicifuga racemosa	Black cohosh, black root, bugbane, rattle root	Chronic ovariitis, endometritis, amenorrhea, dysmenorrhea
Caulophyllum thalictroides	Blue cohosh, squaw root	Abortion, uterine inflammation, laxative, sore throat, hiccups, epilepsy
Serenoa repens	Saw palmetto	Benign prostatic hyperplasia
Taraxacum officinale	Dandelion	Laxative, improving digestion, hepatoprotective
Camellia sinensis	Green tea	Diuretic, stimulant, blood sugar regulator, antioxidant
Commiphora mukul	Guggul gum	Obesity, hypolipidemic, antihypertensive
Hoodia gordonii	Bitterghaap, bokhorings, Ghaap	Gastric acid reduction
Viscum album	European mistletoe, common mistletoe	Cancers
Trifolium pratense	Red clover	Menopausal symptoms, asthma, syphilis, quitting smoking
Stevia rebaudiana	Sweetleaf, honey leaf	Natural sweetener

ADR = adverse drug reaction.

Finally, I note Dr Holyoake is a clinical oncologist by specialty, which illustrates there is a demand in non-respiratory higher specialist trainees to learn bronchoscopy in view of techniques such as bronchoscope-guided radiofrequency ablation and brachytherapy (anaesthetics and interventional radiology being the other specialties). It will be important for those with responsibility for bronchoscopy learning programmes to facilitate such cross-specialty interest without any negative impact on learning opportunities for higher specialist respiratory trainees. In this respect also, virtual bronchoscopy simulation is a welcome development.

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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.

Self-administration of medicines by inpatients: are we making any progress?

The central theme of the NHS plan is to empower patients to take an active role in the management of their conditions. Self-administration of medications (SAM) by patients in hospital improves compliance and comfort, and empowers patients as they are actively involved in their care.¹ The Audit Commission report in 2001 had shown variability in the uptake of self-administration policies in different NHS trusts.¹ The Healthcare Commission's review on medicines management in hospitals in 2005/2006 showed that only 19.5% of the eligible wards actually offered it.² It regards 'progress towards self-administration' as a performance indicator in the annual health check on the medicines management aspect of any hospital.

The opportunity for self-administration should be offered to all competent patients, especially where the timing of the medications is crucial, as with diabetes, Parkinson's disease and asthma.

In diabetes, most medications are to be taken around mealtimes. A document published by

NHS Diabetes in March 2012 encourages patients with diabetes to self-administer and adjust insulin in collaboration with a healthcare professional.³ An audit performed at Warrington General Hospital NHS Foundation Trust examined adherence to the SAM policy by staff in the context of diabetes medications and patients' knowledge and attitudes towards inpatient self-administration. There is currently little published evidence that explores patients' perspectives on this issue.

Fifty competent inpatients with diabetes were selected and data were gathered by interviewing staff and asking patients to complete questionnaires. Among those on oral agents (n=25, 50%), none were allowed to self-administer. 43% of these patients were not aware of the SAM policy and would have liked to self-administer (Fig 1). Patients in this group were between 57 to 88 years of age (median 70 years). In the injectable (n=25, 50%) group, 76% were aware of self-administration. 56% of these actually self-administered and 45% of those who didn't self-administer would have liked to (Fig 1). There was also a perceivable, but not quantified, ambivalence among the staff on this policy. A major limitation quoted as a hindrance to the execution of the policy was time constraint, as risk assessment for self-administration

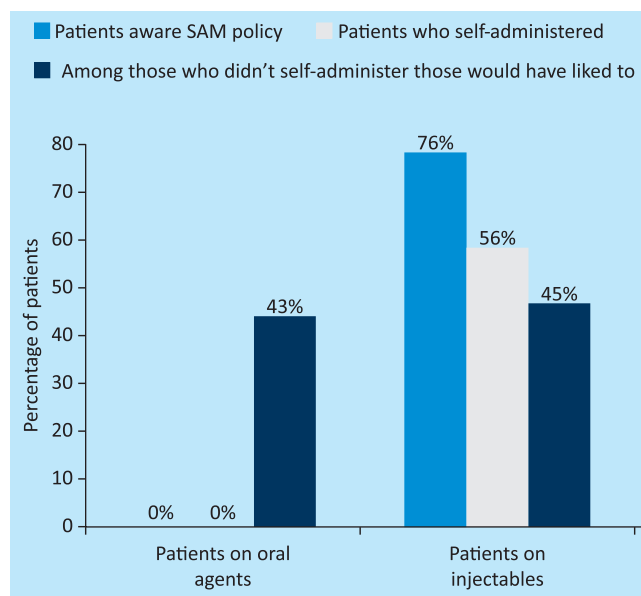


Fig 1. Awareness of SAM policy and level of self-administration among competent inpatients with diabetes. SAM = self-administration of medicines.