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The impact of consultant-delivered multidisciplinary inpatient medical care on patient outcomes

Editor – We read with interest the article by Fielding *et al* which assessed the impact of consultant-led multidisciplinary team (MDT)-delivered care on length of stay (*Clin Med* August 2013 p344–8). Taken together with the earlier study by Ahmad *et al*,[1] there appears to be mounting support that increasing consultant-delivered ward rounds is associated with shorter length of stay. However, at our own institution we found that the introduction of two extra consultant 'winter pressure' ward rounds by the respiratory and general internal medicine (GIM) teams was associated with only a very modest saving in average length of stay when compared to the non-respiratory/GIM teams, who continued with two formal ward rounds per week (Table 1). Furthermore, an earlier start time of 8am did not appear to influence the time of TTO ('to take out' prescription) printing or the time of discharge.

While the data presented by Fielding *et al* are encouraging, we urge caution before widespread implementation of daily consultant-delivered care. As stated in the conclusion, their study was not a randomised controlled trial (RCT) and is open to considerable selection bias. Furthermore, they do not include a formal health economic analysis in their report, nor do they comment on the experience of the consultants concerned in terms of the sustainability of such high intensity work.

Despite the strongly worded conclusion of the Academy of Royal Colleges report[2] recommending daily consultant-delivered care, to our knowledge there have been no RCTs performed in this area. The cost of employing sufficient consultants to deliver a consultant-led ward service will be substantial and persuading new consultants to sign up to delivering care without trainees will be challenging. While we support the concept of early and regular patient access to senior clinical decision makers, we advocate the collection of more robust data before the widespread introduction of daily consultant delivered care on general medical wards.

References

1 Ahmad A, Purewal TS, Sharma D, Weston PJ. The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards. *Clin Med* 2011;11:524–8.
2 Academy of Medical Royal Colleges. *The benefits of consultant-delivered care.* London: Academy of Royal Colleges, 2012. aomrc.org.uk/component/docman/doc_download/9450-the-benefits-of-consultant-delivered-care.html [Accessed 27 September 2013].

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Table 1. Impact of additional ward rounds and 8am start.

	Average length of stay (median (IQR) days)		TTO printed before 1pm (%)		Discharged before 1pm (%)	
	Four rounds at 8am	Standard care	Four rounds at 8am	Standard care	Four rounds at 8am	Standard care
Pre-intervention*	7.0 (9.0)	9.0 (16)	29.5	27.0	16.8	19.9
Post-intervention*	7.0 (8.0)	10.0 (21)	32.6	29.3	18.0	20.2
p-value†	ns	0.012	NS	NS	NS	NS

IQR = inter-quartile range; NS = not significant; TTO = to take out [discharge prescription]. *Intervention = two additional ward rounds and 8am start.
†Mann-Whitney U test

A trainee's guide to surviving ePortfolio

Editor – This is a follow up to Dr King's paper on the ePortfolio (*Clin Med* August 2013 pp 367–9). The Foundation Programme, workplace assessments and local faculty groups (foundation process) were implemented to accelerate foundation doctors' progression to expertise sufficient for full registration with the General Medical Council (GMC) and then into higher training. Vance *et al* reported trainees' considerable dissatisfaction with the processes.[1] In the August edition of *Clinical Medicine*, Dr King wrote 'whether or not you like online portfolio systems, ePortfolio seems here to stay as a tool for assessment and advancement'. I believe the ePortfolio system may require swift changes to make it 'fit for purpose'.

In July 2013 I ran an online survey promoted on Twitter, which attracted responses from 36 consultant supervisors and 88 current foundation year (FY) doctors (32 FY1, 56 FY2). 75% of supervisors and 58% of trainees were not confident that the foundation process was 'fit for purpose' in supporting and accelerating training. 75% of supervisors were not confident that the process provides valid information to recommend full GMC registration at the end of FY1 or progression into higher training from FY2, a view shared by 62% of trainees. Only 33% of supervisors and 36% of trainees found the ePortfolio easy to use. 67% of supervisors felt irritation or dread when asked to complete an online assessment. 31% of supervisors had not read any of the foundation curriculum, whereas 30% of trainees had read all and 65% some of the curriculum.

This was a small survey and participants were probably sceptical. However, the results mirror Vance *et al*'s findings. Full registration with the GMC is a weighty matter, as is assessment of FY2 to progress into higher training. Supervisors, trainees and the public must have confidence the processes are 'fit for purpose'. Swift changes are required to restore supervisors' and trainees' confidence in the foundation training process.

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Reference

1 Vance G, Williamson A, Frearson R *et al.* Evaluation of an established learning portfolio. *Clin Teach* 2013;10:21–6.

'Management of a tuberculosis exposure in the immuno-compromised setting – are the NICE guidelines adequate?'

Editor – We read with interest the article by Mujakperuo *et al* on the use of interferon gamma release assay (IGRA) testing for the diagnosis of latent tuberculosis (TB) (*Clin Med* August 2013 pp 362–6). We wish to highlight four important points surrounding the management of TB outbreaks in the immunocompromised setting and propose an original screening algorithm:

1 Immunocompromised patients undergoing anticancer chemotherapy are known to have a higher incidence of TB[1] and a higher inpatient mortality related to TB when compared to immunocompetent patients.[2]
2 Diagnosing active TB in this cohort is difficult as the clinical presentation is often not typical and non-HIV-immunocompromised patients have a higher occurrence of extra-pulmonary TB.[2]
3 Screening for latent TB poses a challenge given the immunological basis of both the Mantoux tuberculin test (TST) and the interferon-gamma release assays (IGRA). NICE guidelines recommend offering immunocompromised patients an IGRA test alone or concurrent with a TST.[3] This recommendation is consistent with the recently updated Canadian Thoracic Society guideline.[4]
4 There is insufficient evidence as to whom we should consider a 'close or casual contact' and what constitutes a 'cumulative exposure' in this context.[3,4]

A patient attending the hemato-oncology day ward at our institution was diagnosed with sputum smear-positive pan-sensitive TB. A multi-disciplinary expert committee devised an original algorithm for contact screening purposes (Table 2).

Persons with a cumulative exposure of more than 4 hrs with the index case were traced. 17 contacts identified underwent screening with sputum sampling, IGRA and chest radiograph (CXR). Round one revealed 2 contacts with positive IGRAs. Both commenced TB prophylaxis. One patient with an abnormal CXR was referred for computed tomography (CT) imaging. Round two of screening, 8 weeks later, identified one asymptomatic patient with an 'indeterminate' IGRA who commenced prophylaxis. Follow up of all contacts continued for 1 year.

We need to exercise extreme vigilance and consider TB as an early differential in this vulnerable cohort. A prompt multi-disciplinary approach minimised the risk for patients in this case. Establishing universal guidelines with standard definitions for 'close contact' and 'cumulative exposure' in this context would alleviate delays in initiating contact investigations in the future instances.

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Table 2. Contact follow-up algorithm.

Sputum	Chest X-ray	Quantiferon	Action
—	—	—	Advise
—	—	+	Treat for latent TB infection
—	+	+	Bronchoscopy
+	+	+	Sputum +/– bronchoscopy
+	+	—	Sputum +/– bronchoscopy
+	—	—	Sputum +/– CT scan bronchoscopy
—	+	—	Bronchoscopy

CT = computed tomography; TB = tuberculosis.

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