Clinical Medicine 2014 Vol 14, No 2: 212–14

Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Developing a 'pleural team' to run a reactive pleural service

Editor – We read with interest Bhatnagar and Maskell's paper on pleural teams (*Clin Med* October 2013 pp 452–456). They outlined a role for palliative care and stated that hospital stays for patients with pleural disease can be protracted; competence with ultrasound is important; and services can be offered in different settings.

We recently published results of a study of patient experience of ascites secondary to cancer.[1] Hospices can be a setting for patients requiring drainage procedures and it is an option for management of pleural effusion for some.

A patient presented to hospital with ascites and was diagnosed with peritoneal mesothelioma in 2002. He underwent radical omentectomy and splenectomy with adjuvant peritoneal chemotherapy. The ascites re-accumulated requiring therapeutic drainage at 2-weekly intervals.

In 2006 a continuous ambulatory peritoneal dialysis catheter was placed to allow repeated daily drainage at home. He described this as 'life changing', allowing him to regain some sense of control.

In 2010 he developed dyspnoea secondary to a recurrent pleural effusion necessitating repeated admissions to the Oncology Centre. He declined the option of an indwelling drain as he already had the peritoneal drain and did not want a second indwelling drain.

In 2011 he was referred to the local hospice to see if there was anything that could be done to improve his experience of pleural drainage. Ultrasound guided pleural aspiration of up to 2 litres is performed every 4 weeks. The patient has had 18 procedures up to August 2013 with a stay of 2 hours compared with the 3 days he used to spend in hospital.

This case led the hospice to work with a local respiratory physician to devise an algorithm for management of pleural effusions secondary to cancer. Even though this hospice has automated defibrillators it was agreed that if patients required pleurodesis this should be performed in hospital as there is a risk of cardiac arrest. Hospices can be an option for repeated therapeutic aspirations. These may be the best option for patients where pleurodesis is unlikely to be successful; aspirations are thought to be needed infrequently or are removed by patient choice. ■

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Reference

1 Day R, Mitchell T, Keen A, Perkins P. The experiences of patients with ascites secondary to cancer: A qualitative study. *Palliat Med* 2013;27;739–46.

Funding of medical education: the need for transparency

Editor – Dacre and Walsh (*Clin Med* December 2013 pp 573–5) have made important comments on medical education and must be right to emphasise the need for transparency. We strongly support this. They point out that funds for education are being diverted to either research or patient care. This is unsatisfactory accounting and devalues medical education.

We suggest the first step in commissioning medical education is to place contracts with all providers inside and outside hospital. Secondly, regular quality assurance visits including detailed student evaluation are needed. Teaching institutions in line with General Medical Council (GMC) guidance are now acting accordingly.

Several implications arise:

- What happens when clinical teaching does not meet minimum standards specified?
- If employees of the medical school are also employees of the teaching hospital, is there a conflict of interest?

In addition to transparency, we believe the single biggest challenge facing medical education in the UK is the progressive loss of empathy in medical students as they go through medical training, as confirmed by a recent systematic review.[1] ■

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Reference

1 Neumann M, Edelhäuser F, Tauschel D *et al.* Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med* 2011;86:996–1009.