

Survey of core medical trainees in the United Kingdom 2013

Editor – I found the survey of core medical trainees in the UK 2013 (*Clin Med* April 2014 pp 149–56), profoundly depressing. If I become ill, heaven forbid that my care should disturb the more pressing needs of a trainee's work-life balance, or worse still, involve them in any 'menial' tasks.

It is unclear whether the dissatisfaction with the current system derives from real inadequacies in their training or from perceived inadequacies based on unrealistic expectations set by medical schools and the deaneries. I qualified in 1973; life was simple – you worked hard and saw and did lots. We all took the view that the busier the job, the better the training. By today's education and training paradigm, with its complexity and bureaucracy, it seems a wonder that I, and others of my generation, obtained the good training that we did and, in contrast to the general air of dissatisfaction that pervades every aspect of this survey, I thoroughly enjoyed myself.

The separation of service and training is misconceived. It is difficult to think of any service activity that does not have some educational content. Nor is there any task that is 'menial'! Trainees see no need at all to work with hospital notes that are labelled and filed in chronological order. That this is dangerous, has the potential to adversely affect patient care and contravenes General Medical Council (GMC) guidance seems to be of no concern, as sorting out the notes is 'menial' and some mysterious handmaidens called ward clerks will materialise and do it for them.

The separation of educational and service activities is costly. Time that could be used to treat patients and teach simultaneously has been paid for twice. Teaching at the bedside cannot be bettered, far less replaced, by classroom teaching or simulation, important though they may be. Trainees need to review patients they have seen with their seniors if there is to be a shared understanding of the quality of care provided, a considered critique and, subsequently, learning.

Trainees receive substantial salaries; it is not unreasonable to expect the majority of their time to be spent in service delivery. Hospitals deliver care; training, however important, necessarily has to be a secondary consideration. In large part, this survey indicates a sense of entitlement unfulfilled. Trainees were told what they should expect and, unsurprisingly in heavily pressed specialties, did not receive what they expected and felt that their training had suffered. That there were almost certainly innumerable chances to learn every day, albeit not in the setting or format prescribed, may have escaped them.

A number of factors are having an adverse effect on the quality of medical training, including the European Working Time Directive (EWTD). There needs to be an urgent reversal of the separation of service and training activities. The apprenticeship model of training was mistakenly consigned to an early grave and should be resurrected. Trainees also need to know that being a good doctor, whether a consultant or general practitioner, is hard work. Best they learn this early on! To misquote John F Kennedy, trainees 'ask not what the NHS should do for you, but what should you do for the NHS'. ■

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Swallowing and oropharyngeal dysphagia

Editor – We read the article by O'Rourke and colleagues (*Clin Med* April 2014 pp 196–9) with great interest, but were puzzled by the absence of any reference to neurological examination. It is our experience that, in the initial stages of the diagnostic process, a primary neurological cause for oropharyngeal dysphagia is rarely considered by general practitioners (GPs) or by ear, nose and throat (ENT) specialists. We suggest that, in cases where bedside assessment has not revealed an obvious cause, an opinion from a neurologist might usefully precede the initiation of videofluoroscopy and other investigations.

A study of patients seen in our tertiary referral clinic with bulbar-onset motor neurone disease (MND) revealed that at least 50% were initially referred to non-neurological services, frequently to the transient ischaemic attack (TIA) clinic, despite a clear history of progressive symptoms in the vast majority of cases.¹ The other major erroneous referral pathway was via the ENT clinic, where 'satisfactory' direct laryngoscopy had been reported. In some cases the combination of dysphagia and weight loss, common in MND with significant bulbar involvement, had resulted in multiple unnecessary oesophagogastroduodenoscopy procedures, delaying the placement of a palliative gastrostomy. Within the realm of neurology there are also valuable clinical observations – in particular that dysarthria invariably precedes dysphagia in progressive neurodegenerative causes of bulbar dysfunction. Conversely, a structural cause must be considered in cases of dysphagia without dysarthria.²

We believe the assessment of dysphagia to be an area of medical education that deserves a dedicated, problem-based approach that cuts across neurology as well as otolaryngology and gastroenterology. There are important ramifications for delayed diagnosis and management, particularly of neurodegenerative conditions, which will become more prevalent with an ageing population. ■

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