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

Collaborative clinician-led research networks

Editor – We commend Rajasekhar *et al* on their development of the Northern Region Endoscopy Group (NREG) in 2007 (*Clin Med* April 2014 pp 107–12) to facilitate high-quality, multicentre research, service improvement and audit activity within endoscopic practice in their region.

The nature of their collaborative research is familiar to dermatology through the 'UK Dermatology Clinical Trials Network' (UK DCTN),[1] which was formed five years prior to the NREG with the aim of prioritising and developing independent, high-quality clinical trials for people with skin diseases. The UK DCTN now comprises a multidisciplinary membership of over 750 dermatologists, dermatology nurses, health services researchers, patients and carers.

Trial suggestions from UK DCTN members are prioritised and developed using a rigorous and predefined process.[2] Funding for individual studies arises from external grant applications made to the National Institute of Health Research (NIHR) and charitable bodies.

The UK DCTN has been successful in securing over £8 million in independent funding over the last 10 years and to date has completed four multicentre randomised controlled trials, all of which have resulted in high-profile publications. An example is the prophylactic antibiotics for the treatment of cellulitis at home (PATCH) (penicillin to prevent recurrent leg cellulitis) study.[3] Other studies are currently either in development or are open to recruitment. This method of working has been particularly beneficial in the research of rare conditions whereby multicentre input is paramount in recruitment of adequate participant numbers.

The importance of building research capacity among healthcare professionals is recognised through an annual award scheme, which is open to trainees, staff and associate specialist doctors, general practitioners and nurses, and the formation of a UK DCTN Trainee Group, which is led by former trainee award holders.

An extension to the success of our UK DCTN initiative is the International Federation of Dermatology Clinical Trial Networks (IF DCTN).[4] This network aims to share good practice in performing independent dermatology clinical trials internationally, to improve the quality of design and reporting of dermatology clinical trials, and to collaborate on undertaking clinical trials of rare skin diseases across the world.

Putting healthcare professionals, patients and carers on the front line ensures the delivery of meaningful and clinically-relevant research which is facilitated by our group.[5] We encourage others to adopt this framework of collaborative research as an efficient method of addressing the many uncertainties that face healthcare professionals and patients. ■

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3 Williams HC, Crook AM, Mason JM; UK Dermatology Clinical Trials Network's PATCH I Trial Team. Penicillin to prevent recurrent leg cellulitis. *N Engl J Med* 2013;369:881–2.
4 International Federation of Dermatology Clinical Trials Network. Available online at www.ifdctn.org [Accessed 01 October 2014].
5 Layfield C, Yong A, Thomas K, Williams H. The UK Dermatology Clinical Trials Network: how far have we come? *Clin Invest* 2014;4:209–14.

Happenings in Hinchingbrooke

Editor – In your editorial (*Clin Med* August 2014 p 333) you question whether making sure that 'doctors and nurses can run things' has caused 'unprecedented turnaround' at Hinchingbrooke. It is perhaps too early to judge the success of our franchise. Nonetheless I shall try to do so but insist the views stated are entirely mine.

The editorial admits quality is hard to measure. I agree, but believe it has improved. An anecdote may interest readers. While on leave two years ago, I received an urgent email from a ward manager (sister) on a Friday afternoon. Two junior doctors were trying to cope with the preweekend combination of 30 ill patients, irate relatives and 'must-do' to-take-out prescriptions. The rest of the team had been reallocated to 'front-of house' duties in my absence. I emailed senior clinical and management colleagues about the situation. On a whim I copied in the then chief executive officer of Circle Ali Parsa. Within minutes he had contacted the quality lead demanding

an investigation and a report on his desk by the following Monday morning.

Another positive development has been some high calibre appointments. Previously applicants were put off by our uncertain future.

What has not gone so well? Sadly financial balance eludes us. We were one of 19 trusts referred to the secretary of state for failing to break even in 2013/14. This is a far cry from the optimistic projections when the contract was signed.

The press speaks of morale 'soaring' and 'deteriorating'. It depends whom you ask and when you ask them. Undoubtedly, in the first few weeks there was a buzz about the place when all the staff were invited to meetings to develop a bottom-up 16-point strategy. Since then there have been ups and downs. As elsewhere, nursing morale plummets when wards close, reopen or reconfigure. Medical morale suffers when doctors have to do extra duties at short notice.

The management has gone through changes of personnel and structure. Initially we were divided into a large number of clinical units led by a senior doctor, nurse and middle manager. These typically represented one or two wards or services. They have since been rationalised into fewer, larger units. Ironically, the current make-up is similar to our first unit management board in 1987. I entirely endorse doctors and nurses making the decisions. Sadly, then as now, scope is limited by external diktat and stringent short-term financial targets. ■

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A new kid on the block: the role of physician associates

Editor – You called attention to the possibility of using physician associates (PAs) as one part of the solution to the insufficient number of emergency medicine trainees (*Clin Med* June 2014 pp 219–20). In the USA, where the profession has been established for 45 years, more than 10% of all US PAs practise emergency medicine and 68% of teaching hospitals employ PAs in the emergency department.[1] Although the PA profession is in its infancy in the UK, emergency medicine is one of the most common specialties for British PAs.

In the spring of 2014, we conducted the fourth annual census of British PAs. An online survey link was sent to all PAs who have graduated from one of the recognised PA programmes, all members of the UK Association of PAs, all registrants on the PA Managed Voluntary Register and all known American- or Canadian-trained PAs in the country. In total, 134 (70.2%) responded out of 191 PAs believed to be living in the UK and eligible to practice as a PA.

Of all the PAs surveyed, 17 (12.7%) indicated that they practise emergency medicine. The median number of hours per week worked by PAs in emergency medicine was 37.5 and the median pay was £35,000 per annum. Emergency medicine PAs had a median of 2-years' experience as a PA and just over 1 year of service in their current post. Two USA-trained PAs had more experience, with one working as a PA for 25 years and one for almost 6 years.

Self-report of scope of practice by PAs reveals substantial variability. All (100.0%) respondents reported performing history taking, physical examinations and patient education. Eight of the PAs regularly perform psychiatric assessments (47.1%). All PAs perform minor procedures, such as cannulation, whereas a minority perform procedures which are either more invasive or require further training to achieve proficiency (Table 1). The most invasive procedures were, in general, performed by the PAs with the most clinical experience (data not shown).

The number of PAs practising emergency medicine is still small. However, the number of UK-trained PAs in emergency medicine is growing. Between 2011 and 2014, the number of

Table 1. Census responses on scope of practice in PAs in emergency medicine.

Procedure	Number able to perform procedure (n=17)	Percentage able to perform procedure
Venipuncture and cannulation	17	100.0
Suturing	16	94.1
Interpret ECG	15	88.2
Urinary catheterisation	14	82.4
Reducing fractures and dislocations	11	64.7
Nerve blocks	9	52.9
Nasogastric tube insertion	7	41.2
Focused assessment with sonography for trauma ultrasound	3	17.6
Intubation	3	17.6
Arterial/central lines	2	11.8
Lumbar puncture	2	11.8
Chest drains	1	5.9

ECG = electrocardiogram; PA = physician associates.