

## Letters to the editor

### OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: [clinicalmedicine@rcplondon.ac.uk](mailto:clinicalmedicine@rcplondon.ac.uk)

### Recognised training routes are needed to sustain new maternal medicine networks

The recent Department of Health (DH) announcement of funding for training obstetric physicians to help run maternal medicine networks is a much needed initiative to address health inequalities and avoidable maternal deaths, but recognised training routes for these physicians are needed to guarantee long term sustainability of maternal networks.

In 2015, the United Nations' fifth millennium development goal to reduce the maternal mortality ratio by three-quarters was not met.<sup>1</sup> Even in Britain, women die from preventable and treatable medical conditions such as asthma, epilepsy, heart disease and diabetes during and after pregnancy.

In December 2017, the annual Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK) report into maternal mortality in the UK and Ireland was published.<sup>2</sup> As in previous years, the majority of deaths are not directly attributable to pregnancy, but to pre-existing or new onset medical or mental health conditions. The rates of these deaths have consistently remained higher than deaths from obstetric complications, and other than a decrease in deaths from influenza and other causes of sepsis, have not significantly reduced for the last 10 years despite many medical, technological and organisational advances. Reports have consistently shown that improvements in care may have resulted in better outcomes, and of paramount importance is a need to improve diagnosis, investigation and treatment of women with new symptoms. Physicians with expertise in pregnancy are a key component of the multidisciplinary team preventing future avoidable deaths. There are already geographical health inequalities for pregnant women with coexisting medical problems – provision of obstetric medicine is patchy, based on only a very few obstetric physicians working nationally.

Recently, the DH in England published 'ambitious measures to halve the rate of maternal deaths by 2025' as part of the Safer Births strategy.<sup>3</sup> Funding has been committed over 3 years to train 12 consultant physicians as 'obstetric physicians' to establish networked maternal medicine across England. The strategy is clear that the obstetric physician will be a consultant physician working together with a consultant obstetrician (with subspecialist training in maternal medicine) to provide expert care for pregnant women with complex medical problems. The obstetric physician will also provide region-wide leadership and expertise across the whole network to help ensure there is early recognition of problems and access to the best evidence-based care. The MBRRACE-UK report emphasises that establishment of these networks is of

critical importance to prevent maternal deaths and achieve the government ambition.

At present, there are not enough obstetric physicians to deliver these networks and there is no recognised training route for either current or future consultant physicians to gain expertise in pregnancy. There are currently only five full-time equivalent consultants practicing obstetric medicine in the UK and only three centres nationally where appropriate training is available. The vision is that future obstetric physicians will be trained through a recognised physician training programme combined with a medical speciality (such as acute medicine, rheumatology, endocrinology or clinical pharmacology). Obstetric medicine is not currently recognised as a speciality or subspecialty by the General Medical Council (GMC) or the Royal College of Physicians (RCP). There are only a few ad hoc routes by which a trainee physician can gain the necessary training and experience to become an obstetric physician, and only three centres nationally able to deliver this training.

Trainees on an acute medicine training programme can pursue a 'special skill' in obstetric medicine, which requires 12 months of trainee-organised clinical exposure to obstetric medicine. Otherwise, physicians in training must organise a clinical fellowship in obstetric medicine (either during training or after completion of training). There is no agreed curriculum or certificate to recognise this training. Options for accreditation in the absence of creation of a subspecialty include credentialing and discussions are underway. This is in contrast to obstetric training where there is a clear route for senior trainees to undertake an advanced training skills module in maternal medicine.

Without recognised training routes and recognition for physicians to gain this vital expertise in pregnancy medicine, we will not address these health inequalities and avoidable maternal deaths. These reports should provide the impetus to the RCP to establish this training as a matter of priority. ■

IONA THORNE,

*Specialist registrar, Imperial College Healthcare NHS Trust and FMLM National Medical Director's Clinical Leadership Fellow*

CATHY NELSON-PIERCY

*King's Health Partners and consultant obstetric physician, Guy's & St Thomas' Foundation Trust*

MARIAN KNIGHT

*Public health physician and lead for MBRRACE-UK Maternal Programme*

### References

- 1 United Nations' Millennium Development goals. [www.un.org/millenniumgoals/maternal.shtml](http://www.un.org/millenniumgoals/maternal.shtml) [Accessed 14 November 2017].
- 2 MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland*

Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. MBRRACE-UK, 2017.

- 3 Department of Health. *Safer maternity care: progress and next steps*. London: DH, 2017.

### Collaborative research has direct patient benefit and merits recognition

We are pleased that Donovan and Sangha noted our call for collaborative research to be fully recognised by postgraduate training selection panels.<sup>1</sup> However, we are concerned by their conflation of research collaboratives with ‘soft target’ journals which are financially motivated to publish work of such low scientific value, that it would not pass through peer review into a mainstream journal.<sup>2</sup>

Trainee research collaboratives conduct high impact multicentre studies, such as the West Midlands Research Collaborative’s randomised controlled trial ‘Dexametasone reduces emesis after major surgery’ (DREAMS). This 1350 patient trial demonstrated that administration of dexamethasone at induction reduces postoperative nausea and vomiting by one-third.<sup>3</sup> In the evidence-based medicine era, only multicentre studies like DREAMS can change clinical practice. By necessity these are delivered by large, complex teams; 300 coinvestigators contributed to DREAMS across 45 hospitals.

Although DREAMS recruited fewer than 5 patients per coinvestigator, opening the trial at each site, completing mandatory training, screening patients for eligibility, consenting and randomising patients, delivering interventions, and completing follow-up required a significant investment of time over many months; this does not equate to the ‘minimal effort’ outlined in Donovan and Sangha’s letter.

Regardless of whether individuals participate ‘for the love of it’, research collaboratives enable students and trainees to lead and contribute to research that has the potential to improve patient care. Furthermore, it equips them with practical academic skills,<sup>4</sup> promoting further engagement with research and quality improvement across the NHS.<sup>5</sup> STARSurg’s International Journal of Surgery letter argued that it is in patients’ interests for participation in high-quality research such as DREAMS to be fairly recognised by selection bodies on par with other types of publication.<sup>6</sup> This position is supported by the core surgical training, neurosurgery, urology, and general surgery Specialty Association Committees who now recognise collaborative research in award of Certificates of Completion of Training.

We agree that it would be inappropriate to award points in selection processes for short letters. However, recognition of collaborative research is not only wholly merited, but also essential to ensure trainees continue to contribute to high-impact research for patient benefit. ■

### Conflicts of interest

DN was the guarantor for Student Audit and Research in Surgery’s (STARSurg) International Journal of Surgery letter. JCG is the current senior lead of STARSurg ([www.starsurg.org](http://www.starsurg.org), @STARSurgUK).

DMITRI NEPOGODIEV\*

Academic Department of Surgery, University of Birmingham,  
Birmingham, UK

JAMES C GLASBEY\*

Academic Department of Surgery, University of Birmingham,  
Birmingham, UK

\*both authors contributed equally

### References

- 1 Donovan K, Sangha G. The application game. *Clin Med* 2017;17:586.
- 2 Shen C, Björk BC. ‘Predatory’ open access: a longitudinal study of article volumes and market characteristics. *BMC Med* 2015;13:230.
- 3 DREAMS Trial Collaborators and West Midlands Research Collaborative. Dexamethasone versus standard treatment for postoperative nausea and vomiting in gastrointestinal surgery: randomised controlled trial (DREAMS Trial). *BMJ* 2017;357:j1455.
- 4 Chapman SJ, Glasbey JC, Khatri C *et al*. Promoting research and audit at medical school: evaluating the educational impact of participation in a student-led national collaborative study. *BMC Med Educ* 2015;15:1.
- 5 Nepogodiev D, Chapman SJ, Kolas AG *et al*. The effect of trainee research collaboratives in the UK. *Lancet Gastroenterol Hepatol* 2017;2:247–8.
- 6 Collaborative STARSurg. Students’ participation in collaborative research should be recognised. *Int J Surg* 2017;39:234–7.

### Response

We welcome Nepogodiev and Glasbey’s response to our letter. The central thesis of our original piece was that points-based selection criteria for training posts are flawed because they are founded on misleading metrics and do not allow for adequate assessment of individuals’ contribution to research, or of their motivation. While we agree that research collaboratives produce high-quality and high-impact research, we do think that these issues become particularly apparent when considered in the context of a large student or junior doctor research collaborative. This is because, by their very nature, collaboratives rely on distributing a large amount of work over a very large number of individuals, thus reducing each individual’s proportional contribution. One could easily envisage a situation where a canny (but entirely reasonable) junior doctor would take advantage of this distribution of labour to score a ‘point’ which was earned with little work, and the wrong motivation. Such a candidate could easily be identified in a less structured application process with more attention paid to white space and freely flowing interview; however, he or she could not be distinguished by an algorithm based on points-for-publications.

Collaborative research is changing medicine for the better and should be recognised. The problem lies with application systems which only see points and not individuals.

KILLIAN DONOVAN

GINA SANGHA

Oxford University Clinical Academic Graduate School, Oxford, UK

### The hazards of neglecting the skin

Editor – Elder *et al*<sup>1</sup> have addressed the important but overlooked subject of the physical examination. However, as a dermatologist I was disappointed to discover that of 58 different components of the physical examination that they considered, ranging from ophthalmoscopy to digital rectal examination, examination of the largest and most accessible organ of the body, the skin, had been entirely overlooked, other than ‘skin turgor’.

Cutaneous manifestations of systemic disease are numerous and common; the fingernails alone may reveal splinter haemorrhages