References

1 Dhatariya K, Levy N. Perioperative diabetes care. *Clin Med* 2019;19:437–40.
2 Mathew A, Devereaux PJ, O'Hare A *et al*. Chronic kidney disease and postoperative mortality: a systematic review and meta-analysis. *Kidney Int* 2008;73:1069–81.
3 Zanchi A, Lehmann R, Philippe J. Antidiabetic drugs and kidney disease–recommendations of the Swiss Society for Endocrinology and Diabetology. *Swiss Med Wkly* 2012;142:w13629.
4 Hobson C, Ruchi R, Bihorac A. Perioperative acute kidney injury: risk factors and predictive strategies. *Crit Care Clin* 2017;33:379–96.
5 Wheeler DS, Giugliano RP, Rangaswami J. Anticoagulation-related nephropathy. *J Thromb Haemost* 2016;14:461–7.

Making every contact count: the role of the clinician in smoking cessation during the perioperative period

DOI: 10.7861/clinmed.Let.20.2.3

Editor – We read the paper by Durrand *et al* about setting up prehabilitation services with interest and would like to highlight our learning and insight from a local smoking cessation service for perioperative patients.[1]

Smoking is an independent predictor of postoperative complications, and modifications have shown to improve outcomes after surgery.[2] The perioperative period can be an auspicious time to address risk-taking behaviours, like smoking, as patients may be more receptive to making positive changes that can impact their health.[1] Clinicians can play an important role in patient behavioural change by using strategies like Making Every Contact Count (MECC).[1,3]

Smoking has been recognised as the main cause of preventable illness and premature mortality in England and is associated with increased perioperative risk and delayed postoperative recovery.[4,5] Smoking cessation advice and referral has been shown to be cost effective in helping people quit and is an intervention that lends itself well to MECC.[6] Clinicians who are involved in perioperative care can be key personnel in delivering lifestyle advice and referring patients to smoking cessation services.

Yet despite these health risks, nationally there has been a decline in using smoking cessation services and prescriptions for nicotine replacement therapy.[4] In our hospital trust, we found that of 122 patients reviewed in preoperative clinic, 21% (26), were identified as smokers. Of those patients, 65% (17/26) were offered a referral to smoking cessation services of which 76% (13/17) declined. With a 59% attendance rate following acceptance of referral, only 8% (2/26) of smokers seen prior to surgery engaged with smoking cessation services. Some of the barriers to successful referral encountered were lack of behavioural modification training among staff and a significant proportion of patients declining referral when given the option of attending.

The National Institute for Health and Care Excellence recommends that patients who smoke and are planning to have surgery should be referred directly to smoking cessation support services. This opt-out model should be part of routine care and staff should be equipped with the skills to deliver this service.[6] Hence, we suggest training in MECC and behavioural modification should be incorporated into postgraduate medical and nursing training. ■

RATHAI ANANDANADESAN
Specialist registrar in anaesthesia and intensive care medicine, Medway Maritime Hospital, Gillingham, UK

MANISHA SHAH
Consultant anaesthetist, Medway Maritime Hospital, Gillingham, UK

AKURATIYAGE CR DE SILVA
Consultant in anaesthesia, Medway Maritime Hospital, Gillingham, UK

References

1 Durrand J, Singh SJ, Danjoux G. Prehabilitation. *Clin Med* 2019;19:458–64.
2 Leeds IL, Efron DT, Lehmann LS. Surgical gatekeeping-modifiable risk factors and ethical decision making. *NEJM* 2018;379:389–94.
3 Public Health England. *Making Every Contact Count (MECC): Consensus statement*. PHE Publications, 2016. www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf [Accessed 10 December 2019].
4 National Statistics. *Statistics on smoking*. NHS, 2019. https://files.digital.nhs.uk/D9/5AACD3/smok-eng-2019-rep.pdf [Accessed 10 December 2019].
5 Turan A, Mascha EJ, Roberman D *et al*. Smoking and perioperative outcomes. *Anaesthesiology* 2011;114:837–46.
6 National Institute for Health and Care Excellence. *Stop smoking interventions and services: NICE guideline [NG92]*. NICE, 2018. www.nice.org.uk/guidance/ng92/resources/stop-smoking-interventions-and-services-pdf-1837751801029 [Accessed 10 December 2019].

Trends in recruitment into core medical training in the UK – could doing quality improvement projects help?

DOI: 10.7861/clinmed.Let.20.2.4

Editor – Butterworth and colleagues highlight the problems of recruiting and retaining enough medical trainees.[1] They also mention there is a similar crisis in general practice. As medical students who were recently encouraged to become general practitioners (GPs) by conducting quality improvement projects in primary care, we would like to share what we learned. We hope it might be of interest to medical specialties.

To start with, we looked at a range of audits that might be useful to the practice and chose topics based on personal interest. We found it exciting for us as students to have the possibility of influencing clinical practice and improving patient care. This made our projects more enjoyable in terms of academic learning.

We found general practice was a friendly and supportive environment for carrying out an audit. Learning how to create our own databases and doing simple statistical analysis made us feel more confident about carrying out future audits exploring the gaps between guidelines and practice.

We discovered a common theme in our audits – the tension between adhering to national guidelines and feasibility in busy, everyday practice. An example of this was one of our audits looking at whether GPs comply with National Institute for Health and Care Excellence guidelines to screen patients with