Letters to the editor

OVERVIEW

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The association of pleural effusion and pulmonary embolism

DOI: 10.7861/clinmed.Let.22.2.1

Editor – When pleural effusion occurs as a manifestation of pulmonary embolism, this occurrence should generate an opportunity to implement the ultrasonographic pathway for the workup of suspected pulmonary embolism.[1] The first step in that pathway is to perform thoracic ultrasound (TUS) to ascertain whether or not the pleural effusion is attributable to pulmonary infarction. On ultrasonography, the majority of pulmonary infarcts are wedge shaped, but some may either be round or polygonal. Colour Doppler distinguishes pulmonary infarcts from lesions attributable to pneumonia, metastasis or peripheral lung mass.[2]

Ultrasonographic evaluation of all four limbs (for deep vein thrombosis (DVT)) should be the next step in the ultrasonographic pathway. The association of proven DVT and TUS-validated pulmonary infarction should suffice to justify initiation of anticoagulant therapy, thereby obviating the need for further imaging by computed tomography and angiography. That 'short cut' strategy would be uniquely applicable to the hypothetical patient in Ramjug and Phillips' vignette if his chest pain was pleuritic in nature because, in the context of suspected pulmonary embolism, patients with pleuritic chest pain are the ones most likely to have identifiable pulmonary infarcts on TUS.[3] ■

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References

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2 Ghanem MK, Makhlouf HA, Hasan AAA, Alkarn AA. Acute pulmonary thromboembolism in emergency room: gray-scale versus color doppler ultrasound evaluation. *Clin Respir J* 2018;12:474–82.
3 Ramjug S, Phillips G. Update in the diagnosis and management of acute pulmonary embolism for the non-respiratory physician. *Clin Med* 2021;21:e591–7.

Table 1. New complaints to NHS England

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2017–2018	26,948	29,152	27,790	30,099
2018–2019	29,349	29,372	28,019	29,507
2019–2020	28,849	29,625	28,474	26,293
2020–2021	14,142	22,682	23,966	23,109

What is the impact of COVID-19 on complaints against doctors?

DOI: 10.7861/clinmed.Let.22.2.2

Editor – The COVID-19 pandemic is causing unprecedented demand upon healthcare services across the world. This had led to a multitude of changes such as the cancellation of hospital visiting, suspending elective work, redeployment, shielding, working from home etc. Many patients died alone in hospitals, causing tremendous distress and anguish to families. In addition, a significant number of patients died due to nosocomial COVID-19 infection.[1,2] So, what impact did these changes have on concerns against healthcare services? To explore this, we analysed the data available in the public domain on complaints against medical practitioners in the UK.

The number of complaints recorded by NHS England in the first quarter of 2020 (April–June) that coincided with the first peak of the pandemic was significantly fewer than compared with the previous year (14,142 vs 28, 849).[3] However, the numbers gradually increased in the next three quarters, but was still lower than the previous years (Table 1). In Scotland, the number of complaints fell from 32,438 in 2019–2020 to 24,905 in 2020–2021 (Table 2).[4] Also, the number of doctors referred to the General Medical Council (GMC) in 2020 was the lowest reported since 2014.[5] Unfortunately, we were unable to get data for Wales and Northern Ireland despite an extensive search and contacting the relevant bodies.

In view of the terse data available, we could only speculate the reasons behind this pattern. Firstly, at the beginning of the

Table 2. Complaints to NHS Scotland and the General Medical Council

Year	NHS Scotland	General Medical Council
2018–2019	31,802	7,405
2019–2020	32,438	7,464
2020–2021	24,905	7,056