letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Impact of specialist care on clinical outcomes for medical emergencies

Editor – Moore *et al* (*Clin Med* May/June 2006 pp 286–93) provide further evidence to support involvement of specialists in the emergency care of medical patients presenting to general hospitals. In addition, this paper suggests a practical solution to the difficulties in delivering specialist care with the increasing workload that is burdening acute care.

There are, however, alternative explanations for the improvement demonstrated. While the medical workforce is understandably described in detail in this paper, it is possible that other practitioners have influenced the reported improvement. The impact of nurse specialists, advanced practitioners and other professions allied to medicine have all had a demonstrated effect on outcomes.[1,2] The increased numbers of medical and nursing staff described in the paper could also be a major determinant of outcome of medical emergencies.

It is apparent that this unit has made significant changes as a result of the challenge that the delivery of acute care presents, a positive sustained local manifestation of the current national focus, which in itself may have a causative effect on outcomes. Organisational changes such as the expedient of avoiding 'outliers' and the location of service delivery are also beneficial.[3,4] It may be argued that if the mortality reduction is due to specialist care then the additional delays and 'handoffs' involved in an acute medicine unit (AMU) may be counterproductive. The increased early input of resources, including experienced medical staff, may have significantly affected mortality.[5]

In summary, Moore *et al* describe changes in the process and personnel of an AMU that may have heavily influenced the study results, rather than the more efficient use of specialist areas and teams. This work illustrates the conflicts in delivery of acute services when resources can potentially limit quality improvement.

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4 Lloyd JM, Elsayed S, Majeed A *et al.* The practice of out-lying patients is dangerous: a multicentre comparison study of nursing care provided for trauma patients. *Injury* 2005;36:710–3.
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Modernising Medical Careers

Editor – Having been asked by numerous medical students, senior and junior colleagues over the last two years in my role as a clinical tutor in a London teaching hospital to explain whether MMC stands for 'Meddling with', 'Mucking up' or 'Modernising' Medical Careers, it was nice to see a sensible and balanced editorial about the current system from Robert Allan (*Clin Med* May/June 2006 pp 229–30).

While I agree with his comments that time is running short and that we need to offer support to the junior doctors facing this rather confusing beast known as the 'run through grade', I would like to encourage everyone involved to also offer their support to the poor senior doctors who are going to end up living through this transition, as it is they on whom we will rely to get it to work. We previously lost senior registrars for specialist registrars and now they and our senior house officers will ride into the sunset to be replaced by this new breed of doctors who will be aiming for a certificate of completion of training (CCT) instead of a certificate of completion of specialist training (CCST). With an ever-increasing demand put on the goodwill of senior colleagues to keep the service going, our support for them to 'wheel the cogs' of this new system will be imperative if it is to benefit the junior doctors it was designed to train.

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Standardised early warning scoring system

Editor – Validation of a simple prognostic tool with excellent performance characteristics across a range of diagnoses is one of the holy grails of medicine. Such a tool does not currently exist. Paterson *et al* found a linear relationship between in-hospital mortality and a standardised early warning scoring system (SEWS) developed by the Emergency Medical Admissions Scoping Group of NHS Quality Improvement Scotland and suggested that a score of 0 to 3 'should facilitate safe and effective advanced discharge planning' (*Clin Med* May/June 2006 pp 281–4).

We have recently compared the performance of SEWS against CURB65 in predicting 30-day mortality in community-acquired pneumonia (CAP).[1] CURB65 is based on the presence or absence of new confusion, urea >7 mmol/l, respiratory rate ≤30/minute, systolic blood pressure