

letters

TO THE EDITOR

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Healthcare for London: a framework for action

Editor – Professor Holland has written a critique of the *Healthcare for London* report (*Clin Med* April 2008 pp 152–4). Much of Professor Holland's article is focused on criticising the process underpinning the development of the report. A number of his statements are false and we wish to correct them.

Firstly, Holland claims that no lay person or patient was a member of any group. This is not correct. There were a number of lay people involved – representatives from the National Childbirth Trust and the Alzheimer's Association, for example, were members of the maternity and newborn, and end-of-life care clinical working groups respectively – in addition to the 7,000 person survey, and the patients' parliaments.

Secondly, he states that there was a deficit in input from academic researchers. It is not quite clear who Professor Holland would have wanted involved but a number of clinicians with academic posts were included in the clinical working groups – Professor Jane Sandall, for example, was a member of the maternity and newborn group – and an extensive literature search was conducted as part of the review.

Thirdly, he argues that the involvement of front line clinicians rather than academics or public health doctors has led to suboptimal recommendations. It is not clear to us why this should be the case – we would agree that public health doctors are better placed to take a population-based perspective but senior clinicians should be able to give a view on what would consti-

tute high-quality healthcare in their own specialty. Further, we believe that involving the people who will be responsible for delivery services in their design is key to facilitating implementation of high-quality care.

In terms of content, Professor Holland disagrees with the proposal to establish larger primary and community care centres – referred to as 'polyclinics'. His main concerns are that the benefits of integration with specialist care are overstated; and that people would have to travel further to receive care, and thus proposals would negatively impact the most deprived and needy in society. It is worth reflecting on how Lord Darzi and his team came to the concept of polyclinics. Their starting point was the unequivocal view from the participants in the review – public health doctors, general practitioners (GPs), hospital specialists and, most importantly, patients and the public – that the three key priorities for London should be improved management of long-term conditions, increased focus on health and preventing illness, and access to urgent care.

The management of long-term conditions has been shown to be improved by the closer working of primary, community and specialist staff, with access to diagnostics.¹ Many primary care professionals have asserted that they could provide more care for more people if they had greater and easier access to diagnostic services – including simple blood tests, ultrasound and X-rays.

Community and primary care staff acknowledge that gaps between their ser-

vices can result in many of the most needy patients falling between the gaps.

Improved access to health information, support, and high-quality primary care is critical in improving health and preventing ill health. Current primary care is weakest in the most deprived parts of London and this needs to be rapidly addressed. It is not feasible or economic to provide urgent care in every small GP practice in London. Bringing together GPs in a network or single centre will facilitate longer opening hours and allow a broader range of services to be more easily accessible to the local population.

The concept of primary care networks able to offer a wider range of services is not new – it has been mooted in the UK for at least 40 years² and has been adopted, successfully, over that timeframe by many developed countries – most notably the USA, Canada, New Zealand and Germany.

Larger centres, in densely populated areas of London, do not mean significantly longer journey times for patients. We have proposed one centre per 50,000 population as this would provide an efficient operating size and facilitate longer opening hours and investment in diagnostic facilities. Our modelling suggests that for most parts of London this would equate to one centre per kilometre – a reasonable travel time.

As Professor Holland correctly points out, this is not the first attempt to reform and improve healthcare services in the capital and many of the recommendations in Lord Darzi's report echo previous findings. *Healthcare for London*, however, recognises that the architecture of the NHS has now

changed. The principle objective now is to support and encourage the 31 primary care trusts (PCTs) in London to commission high-quality services – services which the population of London deserve and expect.

Since it is London's 31 PCTs that have the legal duty to consult on any proposals for significant change in services, they are now engaged in that process. It is those PCTs which will reflect upon the outcomes of the consultation and according to what they hear will then plan the next steps. Those next steps will require further consultation.

The PCTs have the duty to improve the health and healthcare of their population and they have the power of commissioning to carry out that duty. It is the utilisation of this authority that will have the most influence upon change and improvement in NHS services in the future.

RUTH CARNALL
Chief Executive
NHS London

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Spheres of medical influence: Academic Vice President, Royal College of Physicians

Editor – I greatly enjoyed Jane Dacre's thoughtful and thought-provoking piece (*Clin Med* February 2008 pp 13–5). There were two main themes. Firstly, that medical voices were not always effective in influencing policy even when bodies such as the British Medical Association, specialty societies and royal colleges had been consulted (a theme loudly echoed in the Tooke Report¹). Secondly, that the demography of medical 'leadership' positions does not truly reflect the range or gender of practising doctors. I would like to add the following observations.

I have seen at first hand the extent and usefulness of often unpaid and unrecognised but vital work put in by clinicians who go the extra mile to contribute to local service leadership, postgraduate education, health policy and guidelines. However, I have also witnessed colleagues participating in external activities largely motivated by the

desire for recognition, advancement, financial reward or the glamour of being close to the levers of power. Within trusts, medical managers often have little formal leadership training and are at best 'tolerated' by general managers so long as they are not too challenging of what should be their primary patient advocacy rather than 'corporate' role. Independence of thought and vision is not always rewarded; implementing government directives and targets is what counts. Likewise, in royal colleges or deaneries the way to advancement is to subscribe to the tribal norms and not be too troublesome. If we look at the behaviour which is rewarded/penalised, and the amateur 'Buggin's-turn' ethos, there is a clue to the leadership vacuum identified by Tooke and others.² In my experience, this is one of the reasons why so many able and committed female or overseas colleagues prefer to stick to local service leadership where they can see tangible gains for their effort and are put off many external roles. It's not all about work–life balance or discrimination.

Moving onto representativeness, an issue not really alluded to by Dacre is the inherent and overwhelming bias in the values of British medicine towards academia. Most physicians, for instance, work in busy district general hospitals dealing largely with patients who are ageing, or frail or with multiple long-term comorbidities. The service is largely about successfully managing common conditions with standard treatments. Not only is there a covert prestige hierarchy of diagnoses/specialties but there appears to be an assumption that the true leaders of the profession are academics based in tertiary referral centres and preferably those dealing with cutting-edge technologies.³ A trawl through the names at the 'top' of most royal colleges and specialist societies will confirm this impression. This situation has been compounded by research performance frameworks which reify basic lab-based science and lucrative pharmaceutical research over research concerning service delivery, making academic clinicians even less representative. At its most extreme, this leads to chairs in disciplines appointed on the basis of their research expertise but with little training, competence or day-to-day activity in that craft. An academic contract signals a highly trained mind and

more readily lends itself to external activities, but is no guarantee of having the right expertise or leadership skills to influence front-end service delivery or health policy. Meanwhile 'coalface' clinicians who have developed or led busy local services are under represented. This is an imbalance that has to shift. At the moment, I believe that such doctors, along with many female or overseas colleagues, survey the landscape and vote with their feet.

DAVID OLIVER
Senior Lecturer, Elderly Care Medicine,
University of Reading;
Honorary Consultant Physician,
Royal Berkshire Hospital, Reading

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Never say die?

Editor – Alex Paton accuses those who oppose assisted dying of doing so on the basis of 'confusing definitions, inappropriate ethics and more than a whiff of hypocrisy', and yet his own article is suffused with examples of the same (*Clin Med* February 2008 pp 106–7). Paton implies that the only way to achieve a 'gentle and easy death' is through euthanasia, and that opposition to the latter includes an unwillingness to 'help at the end of life'. He dismisses worries about the 'slippery slope', yet at the same time espouses and hints, quite rightly, at the inevitability of such extensions of practice beyond that allowed in initially limited legislation. Sadly, he also reinforces some of the misunderstanding that may fuel public support for assisted dying¹: he seeks to blur the distinction between withdrawing treatments that are becoming increasingly futile, and actively killing²; and the doctrine of double effect is increasingly being seen as a 'red herring' in end-of-life care, as opioids and sedatives need not hasten death when used appropriately.

Paton is right that there will always be some people who would like the option of assisted dying. Many of us would no doubt

aspire to an ideal of fully informed autonomy that is free from internal conflict and external pressure. Yet, in reality, most decisions at the end of life are messy and involve those who are physically and psychologically vulnerable. The option of assisted dying may in fact deny to some the gentle and easy death that would otherwise be theirs. What represents the greater injustice – not killing those who want it (and for whom alternatives are available), or killing those who do not really want it? Even in the Netherlands, which arguably has the most robust safeguards of any jurisdiction that allows assisted dying, the latest official survey concludes that the transparency envisaged by the Dutch law does not extend to all cases of euthanasia.³ It is then down to the arithmetic of suffering. How many patients dying under similar legislation, before they would otherwise have wanted, would be acceptable in order to provide for one particular version of a gentle and easy death?

JEFFREY STEPHENSON
Consultant in Palliative Medicine,
St Luke's Hospice, Plymouth

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In response

I enjoyed Dr Stephenson's account of my many misdemeanours, but attacks *ad hominem* are usually a sign that one's opponent has nothing to air but his own prejudices. Of course I do not believe that euthanasia is the only way to a comfortable death. Of course I do not 'espouse the slippery slope' when I imply that inoperable cancer and intolerable suffering will be seen to be too narrow an indication as euthanasia comes to be acceptable in the future (and I provide a list you can argue about). And to go on the offensive, Dr Stephenson says that 'most decisions at the end of life are messy',

and in one of my previous articles I quoted a hospital nurse who said, 'You can't provide [the dying] with what they really want'. Perhaps Dr Stephenson and his colleagues should be doing something to clear up the mess – with the help naturally of patients who have made their own preparations for death. A final point that needs emphasising is that we are getting hot under the collar about a tiny number of people: only 171 requests were received in Orlando between 1998 and 2003 following legalisation of euthanasia.

But why are we arguing like this? I have said repeatedly that the views of both sides in emotive issues like euthanasia should be respected and accepted. If we do not, it is possible to envisage a much more dangerous slippery slope, from angry confrontation to public outcry, riots and even war.

ALEX PATON
Retired Consultant Physician, Oxfordshire

Never say die?

Editor – I must take issue with Alex Paton in regard to his use of language (*Clin Med* February 2008 pp 106–7). Despite its linguistic origins, euthanasia and 'a gentle and easy death' are not synonymous terms. Surely even the most vociferous opponent of euthanasia would not wish Dr Paton anything other than a peaceful end when his time comes. However, they would certainly question the suggestion that they should take steps to end his life before that time. I am also concerned at the use of statistics; Paton suggests that, although the great majority of those responding to the survey conducted by the Royal College of Physicians in 2006 were opposed to assisted dying, this is not a representative number – surely this must work both ways and so he can not infer that the silent majority would agree with his position. In attempting to counter any suggestion of 'slippery-slope' arguments, Paton refers to the figures for euthanasia from Holland and Oregon, however the accuracy of reporting in both jurisdictions is far from clear.

There is much more at stake here than the mere wishes of individuals 'who find the idea of assisted dying morally repugnant'. The doctrine of sanctity of life 'has long been recognised in most, if not all, civilised societies throughout the modern

world, as evidenced by its recognition in international conventions on human rights'. The principle of sanctity of life protects the most vulnerable in society and weakening its power would have far-reaching consequences. Paton describes 'horror stories' about aggressive care at the end of life. Respect for sanctity of life is not the same as vitalism, that is, believing that all attempts must be made to preserve life regardless of the cost. There is a 'time to die', and we must improve our ability to recognise that time, to recognise the limitations of our abilities, and hold back from distressing and unhelpful interventions. We must not, however, confuse our failings here with a need to hasten the end.

MICHAEL TRIMBLE
Consultant Physician
Belfast City Hospital

How does the brain process music?

Editor – I read with interest the article reviewing music processing and the brain with evidence from many clinical studies where brain lesions lead to specific auditory processing defects (*Clin Med* February 2008 pp 32–6). I would like to add that in order to help understand how the brain processes music, there is helpful evidence provided from studies in physics and mathematics. We have come a long way in waveform analysis since a series of elegant experiments by Faraday and Maxwell in the 19th century.^{1,2} In sound analysis, there is one particular method of processing waves which is particularly important. This is the Fourier transform, which is now extensively applied in many practical situations involving sound processing, such as noise reduction in audio or electrocardiographic equipment.

Fourier, a 19th century mathematician, analysed the separation of waves into components of different frequencies. The ear and the brain formulate an analogy of the process demonstrated mathematically by a Fourier transform.³ In this process, the ear converts sound waves which come in a large packet or combination of waves into smaller individual wave components, thus allowing further analysis by the brain. In addition, experiments in artificial neural networks and the concept of nerve signal reinforcement (Markov processes)⁴ have shown that the network of nerves can select

a large number of these smaller components to form sensible combinations or patterns. This process of breaking down sound waveforms and reformulating into combination of nerve signals, allows the brain to distinguish the different frequencies of sound which form the individual notes, different pitches in music, music combinations (harmonics) or noise.

LOK YAP
Consultant Physician
Whittington Hospital, London

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Misuse of 'toxin'

The helpful article by Thanacoody and Waring on toxic effects on the cardiovascular system mistakenly described the substances involved as 'toxins' (*Clin Med* February 2008 pp 92–5).

For more than a century that term has been applied only to complex substances, almost always of biological, origin form plants, micro-organisms etc, and not to simple organic chemicals of the type discussed in that paper. The distinction is recognised in standard 'British' and 'American' English dictionaries, eg the Oxford English and Webster's dictionaries, in specialised dictionaries, such as Dorland's and Mosby's, and in the titles of many journals and monographs.

The specific term 'toxin' is valuable because it immediately alerts the reader to the general nature of the chemicals being considered and the likelihood of special features of their origins, properties and effects. The simpler, organic substances may be called 'toxic chemicals' as there is no single equivalent word other than the less familiar 'toxicant'.

Please let us maintain a helpful linguistic distinction in English and one that is also mirrored in many other languages.

ANTHONY D DAYAN
Retired Professor of Toxicology, London

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

A new differential for pyrexia of unknown origin?

I was recently involved in the care of a patient under investigation for pyrexia of unknown origin. He suffered from isolated spikes in temperature every evening and occasionally in the morning. During a ward round I noticed that an infrared ear thermometer was being used to take his temperature immediately after he removed headphones connected to his bedside television. On further questioning the patient reported that he had been using his headphones very frequently and he was often asked to remove them to have his temperature recorded. Having obtained the instruction leaflet for the thermometer I discovered that headphones should be removed a least 20 minutes before use. Could this be a new addition to the differential for pyrexia of unknown origin? If this is the case then a large number of admissions may have been unnecessarily prolonged.

CHRISTOPHER COYLE
Foundation Year 2 (general medicine)
Luton and Dunstable Hospital

Poor communication: 'hot' dictation rather than pro formas?

The consultant post-take ward round (PTWR) is a critical time for reviewing the relevant history, examination and investigations and planning further investigation and treatment. Poor documentation is common and limits the benefits of consultant decisions on patient care. Pro formas have been proposed as a possible solution to this.

In support of this, a PTWR pro forma introduced locally in 2003 significantly improved PTWR documentation in four key areas: differential diagnosis, management plan, deep vein thrombosis (DVT) prophylaxis, and resuscitation status.¹ Pro formas, however, are not long lasting. Ho *et al* noted an initial improvement in surgical records by a clerking pro forma which had significantly declined only three years later.²

In 2007, PTWR pro forma documentation was reassessed (having anticipated that completion was poor) with added stringency of a PTWR consultant countersignature (in the hope this would improve completion). In the study, 75 clinical records were examined. Quality of the PTWR documentation was assessed for the same criteria used in the 2003 study (Table 1).¹ Three additional assessed parameters included clerking doctor bleep number and rank, and PTWR consultant countersignature.

The results from 2007 are shown in Table 1 (Fishers exact test, Graph Pad Prism version 4). Only 72 of the 75 examined records had a documented PTWR. There was a significant decline in three parameters (patient name, clerking doctor name and blood results). A less significant decline was observed in four other parameters (consultant name, differential diagnosis, management plan and electrocardiogram results). Significant improvements were noted in only two parameters (hospital number and DVT prophylaxis). Other parameters were unchanged. The supplementary parameters (bleep number, rank and consultant countersignature) were present in low proportions (33, 29 and 12% respectively).

These results have obvious serious implications on patient care. Although not measured in this audit, it is likely that similar problems in communication to primary care on the discharge papers occur for the same reasons. This increases the chance of hospital readmission as the general practitioner (GP) is unable to access sufficient information about recent admission.

This study confirms that the previous benefits of a PTWR pro forma on standards of documentation decline over four years despite the implementation of a consultant countersignature. Maintaining high quality clinical documentation remains

Table 1. Documentation of key items of information on post-take ward round pro forma in 2003, initially after introduction and four years later with consultant countersignature.

Criterion	2003 results ⁵ (n=95; %)	2007 results (n=72; %)	Odds ratio	95% confidence interval	p value
Patient's name	100	94	12.55	0.66–237.1	0.03
Hospital number	81	94	0.25	0.08–0.78	0.01
Consultant's name	98	93	3.47	0.65–18.4	0.14
Clerker's name	81	58	3.06	1.53–6.12	0.0018
Differential diagnosis	96	92	2.07	0.56–7.62	0.33
Management plan	99	93	7.02	0.8–61.5	0.086
CXR	47	51	0.85	0.46–1.57	0.64
Bloods	85	64	3.27	1.55–6.88	0.0018
ECG	57	46	1.56	0.84–2.88	0.16
DVT prophylaxis	24	39	0.50	0.26–0.98	0.04
Resuscitation status	35	36	0.94	0.50–1.79	0.87

CXR = chest X-ray; DVT = deep vein thrombosis; ECG = electrocardiogram.

difficult, despite recommendations by professional bodies and defence organisations. The General Medical Council recommend 'clear, accurate, legible and contemporaneous patient records' and the Medical Defence Union advise legible writing, with a date, time, name and signature.^{3,4}

Future interventions (over and above administering the PTWR pro forma at induction programmes and including the clerker's rank and bleep section on the pro forma) need to be innovative and might include consultant dictation at the point of admission. This would obviously require administrative support and funding but if prospective pilot studies could demonstrate a reduction in patient stay (by improved communication to the wards) and readmission rates (by improved communication to the GP), then in the long term this could potentially be cost saving (and hence attractive to commissioners) and improve patient care.

ANDREW RL MEDFORD
Specialist Registrar, Respiratory and General
Medicine

PHILIP D HUGHES
Consultant Physician, Respiratory and General
Medicine
Derriford Hospital, Plymouth

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Junior doctors' awareness of terminology relating to key medico-legal and ethical principles: a questionnaire survey

Trainee doctors often face ethical dilemmas and medico-legal issues in daily practice. However, it is widely perceived that the training in these areas is often inadequate. Furthermore, the awareness of legal and ethical principles among doctors is variable.¹ Junior doctors' familiarity with ter-

minology relating to key medico-legal and ethical concepts was therefore examined.

Methods

Junior doctors in three UK hospitals were surveyed. For this, a standardised questionnaire was developed by a team of senior specialist registrars in geriatric medicine who have experience in the issues covered in the survey (information available from authors). Junior doctors from three hospitals, one university hospital and two district general hospitals were invited to complete the questionnaire, rating their own knowledge and understanding of commonly used medico-legal and ethical terms, on a subjective scale. The consenting junior doctors (pre-registration house officer (PRHO) to specialist registrar (SpR) level) from medicine, surgery, accident and emergency and anaesthetic departments in three hospitals in East Anglia completed the questionnaire anonymously.

Results

Over a four-week period, 100 junior doctors consented and completed the questionnaire. Large proportions of doctors had heard of enduring power of attorney (80%; 95% confidence interval (CI): 78.5%, 81.5%) and advanced directive (72%; 95% CI: 70.7%, 73.3%), but fewer than half had heard of the Assisted Dying Bill (43%; 95% CI: 42.3, 43.7). Of those familiar with these terms, the majority felt they did not have a good understanding of each of these terms (Table 1). The majority of respondents felt their postgraduate training in medico-legal and ethical concepts was inadequate: self-reported adequacy of postgraduate training were 78% (69.9, 86.1) and 71% (62.9, 79.1) for medico-legal and ethical issues, respectively.

Table 1. Self-reported level of understanding on legal issues among junior doctors in acute medical specialties.

	Enduring power of attorney	Advanced directive	Assisted Dying Bill
No understanding	21 (26.6; 16.9, 36.3)	8 (11.1; 3.8, 18.4)	16 (37.2; 22.8, 51.6)
Little understanding	36 (45.6; 34.6, 56.6)	30 (41.7; 30.3, 53.1)	20 (46.5; 31.6, 61.4)
Moderate or exact understanding	23 (29.1; 19.1, 39.1)	34 (47.2; 35.7, 58.7)	7 (16.3; 5.3, 27.3)

n (%; 95% confidence interval).

Discussion

The majority of junior doctors in this survey were unfamiliar with medico-legal and ethical terms relevant to daily clinical practice. They also felt their postgraduate training in these areas was inadequate. With ever-increasing public awareness, there is a greater emphasis on patient autonomy. Therefore, it is essential that doctors be adequately trained in ethical and medico-legal aspects of care. The number of participants in this survey was small. Nevertheless, the sample was drawn from junior doctors ranging from PRHO to SpR level in four major disciplines and it is, therefore, likely to be a representative sample of trainees across the UK. A formalised postgraduate curriculum, and interactive practical teaching across all specialties and all grades may help to address the deficiencies identified in this survey.

PK SHIBU
Specialist Registrar

SANTHOSH SUBRAMONIAN
Specialist Registrar

MOHANRAJ SURESH
Specialist Registrar

MADHAVI VINDLACHERUVU
Consultant Physician

SALIM CHEEROTH
Consultant Physician

PHYO K MYINT
Lecturer and Specialist Registrar

*Department of Medicine for the Elderly,
Norfolk and Norwich University Hospital*

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Ethics

The project was conducted using investigating specialist registrars' research sessions and obtained the participants' written consent. The data were collected anonymously and presented in aggregated and anonymised fashion. Therefore, local research ethics committee approval was not sought.

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