

Letters to the Editor

OVERVIEW

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Discharge communication

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Editor – I appreciate the excellent quality improvement research presented by Earnshaw and colleagues.¹ The authors have taken considerable effort with a rigorous approach to improving the quality of discharge summaries through a direct feedback system. I found their 'rapid improvement event' (RIE) using LEAN methodology, and their suggestion of greater involvement of allied healthcare professionals particularly worthy.

The importance of good discharge communication by new doctors was a subject we chose to tackle as near-peer teaching for the then new Final Year Transition course pioneered at Imperial College in 2012. Assessment of written communication, such as discharge summary writing, should by now be embedded in the UK undergraduate medical school curriculum.

Arguably, every junior doctor rotation should provide a specialty-specific induction handbook that includes common condition discharge summary criteria and useful guidelines.

Some are not aware that the annual NICOR National Heart Failure Audit evaluates standards on adequate heart failure planning documentation, discharge weight and electrocardiography findings, based upon discharge summary data. As the authors mention, an association of poor-quality discharge summary with higher rate of readmission for patients hospitalised with heart failure exacerbation has been reported previously in the USA.²

To take another example, in interventional cardiology, procedures are becoming more and more complex, and dual and triple anti-platelet regimens are increasingly convoluted and varied. The importance of clear discharge communication with expert review, for example at registrar or consultant level, is only likely to grow.

I suggest that the role of discharge written communication is not just in ensuring patient safety, for example by reducing prescribing errors and maintaining the long-valued rapport between primary and secondary care practitioners, but also in empowering and educating patients for self-care. There is a paucity of evidence on how this should be delivered.

Furthermore, I would like to propose that high-quality and in-depth feedback to a junior doctor using a discharge summary can be a valuable learning tool, perhaps a more robust approach to the case-based discussion. I suspect that the rich and structured nature of any hospital admission journey would yield a pragmatic and dynamic teaching resource of interest to teacher and student alike.

I look forward to the development of the authors' quality improvement research. ■

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Pleural and peritoneal work in the COVID-19 era in a north-east hospital

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Editor – Northumbria Healthcare NHS Foundation Trust runs a successful pleural and peritoneal service for patients with malignant pleural and peritoneal malignant fluid, pleural infection and pneumothorax.^{1–4} Most of the work is done through medical ambulatory care or semi-elective theatre work. All patient records referred from 16 March 2020 to 17 June 2020 were reviewed. Inclusion criteria were those patients who required an interventional procedure and managed on an outpatient basis. Basic demographics, diagnoses and mode of diagnosis and performed investigations were collected. A descriptive analysis of the data was performed.

Four patients with pneumothoraces were seen (all secondary pneumothoraces). The mean age was 57.5 years, two were treated with a pleural vent over an average of 3 days. Two patients were managed with an ambulatory bag over an average of 22 days.

We previously reported that five patients who had been referred for local anaesthetic medical thoracoscopy (LAT) and symptoms pertaining to fluid were being palliated by indwelling pleural catheters (IPC).⁵ Given cancellation of elective theatre work, day-case LAT was not an option for us. See supplementary material S1, Table S1, for a summary of patients with malignant effusions and their outcomes.

Six indwelling peritoneal catheters for patients with malignancy related ascites were inserted. The mean age was 59.7 years and mean number of preceding paracenteses was 0.67. All were done as day cases. The diagnoses were breast, gastric, pancreatic, bowel and unknown primary cancers. It is worth noting that one of the patients was SARS-CoV-2 positive at the time of the procedure.

We are past the peak of the pandemic and currently looking at ways to restart previous services. It has proved to be a challenging time with the surgical constraints in the COVID-19 era.⁶ The future

is uncertain as a second peak is currently developing in some parts of the world. For the processes that were instigated above, we are better prepared in the event of one. ■

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Supplementary material

Additional supplementary material may be found in the online version of this article at www.rcpjournals.org/fhj:

S1 – Summary of patients with malignant effusions and their outcomes.

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Who should develop massive open online courses (MOOCs) for undergraduate medical education?

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Editor – The future of medical education is online and as the world restructures in the midst of this pandemic there is opportunity for this future to be expedited. As a group of medical students from the UK, we have seen great variation in the content of online education provided by medical schools, in lieu of normal teaching, to cater for

students currently isolating at home. With the likelihood that online courses will become increasingly integrated into undergraduate medical education we believe there is a need for centralised development of high-quality learning resources.

Online education is not novel, with many medical schools already successfully incorporating methods of online teaching, such as the ‘flipped classroom’ model into their curricula.¹ Massive open online courses (MOOCs) have the potential to become the ‘gold standard’ for delivering learning objectives through interactive online teaching and videos, recommended reading, discussion forums and automated assessments. Successful MOOCs already exist, as demonstrated by a joint project by the University of Dundee and British Society for Antimicrobial Chemotherapy (BSAC), who developed a MOOC to compensate for the lack of standardisation of undergraduate antimicrobial resistance and stewardship teaching.²

Medical school curricula are developed locally around core competencies set by the General Medical Council (GMC), leading to inevitable variation.³ We propose that MOOCs should be designed by professional bodies, such as the royal colleges and national societies (eg BSAC), which are actively involved in creating guidelines, setting assessments and developing training pathways for specialty trainees. Developing an effective MOOC requires establishing a central curriculum, identifying a target audience and creating relevant content.⁴ Now is the time for these groups to assemble expert panels, decide upon competencies and repurpose existing online content or create novel resources.

Medical education is a combination of theory and practical experience, with a great deal of learning condensed into a short period of time. While not all learning can take place online, by moving traditional time-consuming theory-based teaching online there is potential to increase time spent in the clinical environment, arguably the most important part of developing future clinicians. Enabling the best possible learning experience for students requires accessible online resources developed by expert groups. Now is the time to identify the professional bodies best suited to develop MOOCs and encourage them to deliver the future of undergraduate medical education. ■

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