Knowledge of aspects of acute care in trainee doctors

Aspects of acute care which may be more fundamental than those elicited by the questionnaire of 12 acute care topics include criteria which enable healthcare workers (including junior doctors and nurses) to be more easily able to identify the seriously ill patient. This issue has been addressed by a study validating the use of a modified early warning score in medical admissions. The parameters evaluated in that study included blood pressure, pulse, respiratory rate, temperature, and conscious level, the latter simply characterised by documentation of alertness, reaction to vocal stimuli, reaction to pain, or absence of all three, as in the unconscious patient. In view of the proven efficacy of the scoring system utilised in that study, the “take away message” is that this is what juniors and nursing staff should be trained to evaluate, and it is the opportunity to instil these basic principles which should be optimised by promoting the ideal of teaching medical students and student nurses together at some stage in their respective training programmes. Furthermore, in order to maintain the momentum of shared educational objectives, doctors and nurses should utilise an integrated health record which should replace the present system of separate medical and nursing notes.

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References


Confidence levels of PRHOs in caring for acutely ill patients

We read with interest the paper by Smith and Poplett.1 We agree that trainee doctors appear to have significant gaps in their knowledge and understanding of acute care. At our hospital, before the introduction of the ALERT course2 for pre-registration house offices (PRHOs) and nurses on the general surgical wards, a questionnaire was completed by a group of medical and nursing staff. The aim of the questionnaire was to identify how confident junior doctors are in caring for critically ill ward patients, and any particular areas of perceived knowledge or skill deficit. Clinical scenarios were used and respondents were asked to rate on a scale of 1 (low) to 5 (high), their level of confidence. For example, one scenario described a postoperative patient after total colectomy, who has an epidural in situ. The patient is hypotensive, oliguric, and pyrexic. The PRHOs felt reasonably confident (mean score 3.5) about assessing the patient’s fluid status clinically, identifying the likely causes of hypotension and oliguria, and assessing the response to fluid challenges and interpretation of central venous pressure readings. They were more confident (mean score 4.0) about assessing arterial blood gases, performing 12-lead electrocardiography, and recognising arrhythmias. However, doubts were expressed over the differences between colloid and crystalloids.

They lacked confidence (mean score 2.6) about practicalities such as using a pressure bag to rapidly infuse fluids, and in their knowledge of the cardiovascular effects of epidurals. Nursing staff however perceived a different pattern of knowledge and skill deficits. While these are subjective self assessments of knowledge and skill relating to the management of critically ill patients, this model has allowed us to tailor educational strategies to target areas of perceived need.

During the introduction of the ALERT course in our hospital, we were interested to see what impact if any, there would be on the PRHOs management of acutely ill patients. After running a number of ALERT courses we noticed that the documentation by PRHOs in the medical record was significantly more structured, following an A, B, C-type approach. A small audit of the medical reviews of sick ward patients by PRHOs, before and after introduction of ALERT, appeared to confirm this. An arbitrary scoring system was devised and points were awarded for the documentation of details such as reviewing doctor’s name, contact details, respiratory rate, capillary refill, etc. From a possible total score of 12, the mean score before ALERT was 4.54 and after ALERT was 7.75, an improvement of 70%.3

Using a combination of generic critical care training such as ALERT and specific targeted educational packages as part of critical care outreach, does appear to improve the management of sick ward patients by PRHOs.

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Authors’ reply

The comments of both Jolobe and Hutchinson and Robson complement the message of our paper—that is, that there is room for improvement in aspects of acute care of patients.1 We believe that, as well as an inadequate level of knowledge by trainees, factors such as poor or late recognition of disordered physiology, suboptimal clinical management, poor communication, poor record keeping, and lack of teamwork lead to deficiencies in care. All of these topics are currently being approached at the end of their first post (four or six months after qualification).

When questioned, 53% of those who had completed only a medical attachment felt confident in making a diagnosis and treating a patient with an acute abdomen. Of those who had completed only their surgical attachment, 91% felt confident to diagnose and treat pneumonia, 73% acute left ventricular failure, and 50% an exacerbation of chronic obstructive pulmonary disease. Six percent even felt able to decide when to administer thrombolysis to a patient requiring it for myocardial infarction (despite having no medical experience at all).

Knowledge of aspects of acute care in trainee doctors

We read with interest the article by Smith and Poplett. In a recent study, the results of which are currently being completed, the questionnaires were approached at the end of their first post (four or six months after qualification).

When questioned, 53% of those who had completed only a medical attachment felt confident in making a diagnosis and treating a patient with an acute abdomen. Of those who had completed only their surgical attachment, 91% felt confident to diagnose and treat pneumonia, 73% acute left ventricular failure, and 50% an exacerbation of chronic obstructive pulmonary disease. Six percent even felt able to decide when to administer thrombolysis to a patient requiring it for myocardial infarction (despite having no medical experience at all).
Earlier this year Smith and Poplett discussed the experience level of the doctors questioned by Smith and Poplett was not clear. Had the PRHOs started work at all? In which year were the SHOs and had any of them completed advanced life support courses? It would be interesting to take this into account, while highlighting the benefit of advanced life support-type courses.

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Should inexperienced trainees be delivering acute medical services?

The authors did not, at any point, consider whether such young and inexperienced doctors should be assessing and treating such acutely ill patients in the first place.

At the time of publication, this article was reported widely by the UK print media and I was interviewed by The Western Mail (the main Welsh broadsheet) for an article that appeared on the front page under the headline Doctor training “puts lives at risk”. I was unhappy with the paper’s interpretation of Smith and Poplett’s research, and because of the potential for public confusion I responded with a long letter to the editor where I made the following points:

1. The findings of the research did not surprise me and the situation is actually much better now than it was in 1993 when I qualified as a doctor. At the time, there was virtually no preparation for the realities of working with NHS, with very little instruction on how to assess and treat sick people, prescribe drugs, take blood, or resuscitate collapsed patients. Instead, we learned very quickly “on the job” and many of us recall with horror our first few weeks as house officers, the pressure we were under, and the mistakes we must have made.

2. There has been a recognition of these deficits over the last few years and the medical school courses across the UK have evolved appropriately. There has been a move away from the traditionally theoretical and highly academic approach to a more “hands on” and integrated course that concentrates on knowledge together with the practical and communicative skills needed to actually work as a doctor. Unfortunately, this paper suggests the process has still not gone far enough.

3. Improving the training of medical students is only part of the answer and it must be remembered that the doctors interviewed were at the beginning of their postgraduate training. Both the British Medical Association and the government are committed to a health service that is delivered by “competently trained doctors” rather than “doctors in training”. It is essential that we move away from the traditional model of care where patients are first seen by the most junior doctors in the hospital. These doctors do not have the experience, training or basic skills to properly assess, diagnose, and treat patients with complicated and life threatening diseases.

4. Patients should be seen at a much earlier stage in their admission by consultants. This would not only provide better levels of individual care but would also ensure more efficient service delivery.

This article highlights the fact that inexperienced trainees lack the competence to deal with much of their workload and supports the argument that we should have a consultant delivered service.

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References
3 Davies I. We need more consultants. The Western Mail 2 July 2002 (letter to editor).

Plain abdominal radiographs in acute medical emergencies: an abused investigation?

I read the article on plain abdominal radiographs in acute medical emergencies with interest, and I agree in many respects about the unnecessary use of abdominal radiographs, especially if the diagnosis is clear. I would, however, like to address a few points with regards to the article:

• I note that the abdominal radiographs were performed on patients admitted under a general medical on-call with acute medical emergencies. It is unusual, in my experience, for patients with medical disorders to have abdominal radiography unless an acute abdomen is suspected. In this situation, the patient would have a surgical abdomen. In this case an abdominal radiograph may be necessary to exclude/confirm obstruction and perforation by demonstrating Rigler’s sign. Consequently, I would say that the plain abdominal film is not an abused investigation as it may determine quite accurately whether the patient has emergency surgery or medical treatment.

• I was interested in the paper by Feyler et al looking at requests for plain film abdominal radiographs in acute medical emergencies. Although the results indicate that plain film radiography is unnecessary requested it fails to address several important related issues. Firstly, the discussion of the paper fails to highlight that the existence of many grey areas in clinical diagnosis, particularly in the subjective symptoms and signs, may influence the decision to request a plain abdominal radiograph as a first objective means of ruling out intra-abdominal pathology. Fuzzy logic (multivalent logic) is a reality in clinical medicine, determined by the Royal College of Radiologists and presumably the doctor on-call considered these as part of the differential diagnosis in patients presenting with abdominal pain.

• I note that for acute pancreatitis, abdominal radiographs were requested. Could it be that this is probably due to standard medical teaching which instructs on the ability of a plain abdominal radiograph to reveal features suggestive of acute pancreatitis (for example, sentinel loop, loss of psosas shadow)?

• An abdominal radiograph may be required to exclude or confirm one of several differential diagnoses if the clinical problem is not apparent. It may be one of the reasons why abdominal films were requested in this cohort. Consequently, I would argue that in this situation, plain films are not an unnecessary investigation.

• Of the 45 patients with a diagnosis that was not stated, what was the eventual clinical impression? Could it be that in this subgroup, the acquisition of a plain abdominal radiograph may have resulted in the correct diagnosis being reached and therefore managed appropriately?

• Also I would say that an abdominal radiograph in an elderly patient with rebound tenderness in the right iliac fossa and signs and laboratory symptoms suggestive of obstruction may be necessary to determine caecal size. How many of the patients had this presumptive diagnosis and had an abdominal radiograph?

• Pre-registration house officers may have ordered the largest number of abdominal radiographs, but how many of these films were requested after discussion with a senior doctor (senior house officer or registrar)? Do the authors have data that give this information?

• It may be essential to do a plain abdominal radiograph to narrow the diagnosis in an acute abdomen. In this case, radiation dose may be minimised by ordering a single supine plain film, rather than the standard erect and supine set of radiographs for the abdomen. Were erect and supine abdominal radiographs obtained in the study?

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because acute clinical signs and symptoms are not as neatly packaged as the Royal College of Radiologists’ guidelines. Secondly, it will be very educational to know the patient profile of the nine patients in whom plain film radiographs influenced clinical management. This is not detailed in the paper.

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Editor’s note: The authors have declined an invitation to comment on the above two letters.

Vacuum assisted closure system in the management of enterocutaneous fistula

We congratulate the authors for their innovative efforts in dealing with a clinically relevant issue.

Indeed this may prove to be a significant breakthrough in the management of difficult enterocutaneous fistulas. However, we were a bit concerned whether an ethical contraindication to the use of the device was to be performed ethics committee approval would be mandatory.

It is not necessary to obtain ethics committee approval for the use of novel treatments in desperate situations. We would agree, however, that if a prospective study of the VAC device was to be performed ethics committee approval would be mandatory.

Saklani and Delicata have raised interesting questions relating to the introduction of new techniques. Do ethical committees have a role in the treatment of individual patients as opposed to the conduct of a clinical trial where different modalities on a particular fistula are under investigation and comparison? With the emergence of bioethics and medical ethics, it should be the role of ethics committees to concern themselves with such issues. However, their role would then include many other aspects of life and death in which clinical interventions played a part. Are ethics committees prepared to take on this role, and are their members adequately trained to fulfill it?

Patients need advocates who can put their view, and although nurses have traditionally claimed this ground, the patient advocate of the 21st century needs to be an independent practitioner. As to informed patient consent, we need to consider informed patient choice where patients choose between options based on a comprehensive package of information. Anything less smacks of medical paternalism.

Vacuum assisted closure system in the management of enterocutaneous fistula

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Indeed this may prove to be a significant breakthrough in the management of difficult enterocutaneous fistulas. However, we were a bit concerned whether an ethical contraindication to the use of the device was to be obtained before treatment. This is because Argenta et al considered dehisced wound and fistula a contraindication to a vacuum assisted closure (VAC) system. Moreover, continuous suction may hamper closure of fistulas. I would be grateful if the authors could shed light on this aspect.

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References

Authors’ reply

We are grateful to Mr Saklani and Mr Delicata for their interest in our report. We were aware before using this device that enterocutaneous fistula has been suggested as a possible cause of Argenta.

It was obtained before treatment. This is because Argenta et al considered dehisced wound and fistula a contraindication to a vacuum assisted closure (VAC) system. Moreover, continuous suction may hamper closure of fistulas. I would be grateful if the authors could shed light on this aspect.

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References
points of history, examination, investigation, and immediate management.

I find the book totally revised and updated in line with our Resuscitation Council guidelines and other subjects. It now includes a new section on environmental emergencies, advanced life support, hypoaemia, hypokalaemia, etc. As we are heading towards clinical governance, I am glad that Tony Brown has included chapters on risk management and incident reporting as well.

Going through the book, I find that the essentials of diagnosis and management are described concisely and fairly, and contain a lot of practical advice.

I find this book a reliable text and will be of enormous help to junior doctors practising accident and emergency medicine for the first time. It is a concise and practical guide. I also feel that this book will be very useful to many nurse practitioners and general practitioners in moments of uncertainty.

This is a good addition not only to a personal library but the departmental library as well.

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Scientific Writing—Easy when you know how.


This book provides clear advice on how to write scientific articles and how to get published. The philosophy behind the book is that doctors are drowning in information with thousands of medical journals published annually and endless material from pharmaceutical companies, Royal Colleges, etc and it is therefore not that difficult to get one's work published but the real challenge is to publish it well and make an impact.

Each chapter begins with a quotation and the text is also interspersed with well chosen quotations that act as signposts easing our journey through the book. Chapter 1 kicks off with a quote from Samuel Johnson “What is written without effort is in general read without pleasure”. The authors even have a quotation to enliven the chapter on statistics “Like dreams statistics are a form of wish fulfilment”.

There is much to be learnt from dipping into this book—for example, did you know that to report the results of a randomised control trial you will be required to follow the CONSORT guidelines? Their “golden rules” for reporting numbers are very worthwhile—for example, numbers less than 10 are written as words and larger numbers are written as the number; do not use decimal places if the sample size is less than 100 etc. Their clear advice on how to title a scientific article is very well worth reading.

The book contains a lot of advice on how to draw up a list of authors and coauthors. With the tendency to increasing numbers of coauthors in medical publications there is sound advice here on the responsibilities and entitlements of all authors and coauthors.

The authors of this book are associate professors, a statistician and an information manager, and have provided a very comprehensive book written in a very clear style and packed full of sound information. The book is beautifully laid out and a model of clarity. They have obviously followed their own advice so that it can be read through from cover to cover, but it is also a useful book to have on the shelf to dip into. I strongly recommend it to all budding medical writers and even well published researchers will find much within its pages to interest.

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Confidence levels of PRHOs in caring for acutely ill patients

S Hutchinson and W P Robson

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