Letters

I just wanted to be a doctor

We need to be more than "just" doctors

Editor—Hunt articulates the feelings of many doctors on discovering that the effective practice of modern medicine requires a range of skills beyond the provision of direct clinical care.[1] Her slightly delayed entry into medicine may explain why this issue is troubling her now, rather than later in her career: certainly these are sentiments I hear more commonly from consultant colleagues than juniors.

However, to imagine that good medical practice is confined to the delivery of care to one patient at a time is to overlook the role of doctors in organising healthcare systems and delivery in the wider context. It is disappointing that Hunt's appraiser chose to frame the process in terms of her trust's participation in the clinical negligence scheme, since most junior doctors value well conducted appraisals. Nevertheless, cheaper insurance premiums for hospitals mean more money to spend on health care, and also indicate that organisations that carry out effective appraisal make fewer clinical errors: presumably these are both outcomes that Hunt would approve of. Furthermore, research and audit without the active participation of doctors will soon become clinically irrelevant or ineffective. We have a wider responsibility for patient care that is served by informed participation in these and many other activities, such as teaching and continuous quality improvement (which also seem to get irritatingly in the way of a narrowly focused approach to patient care).

However, all is not lost. Hunt appears well placed to fall into the "Modernising Medical Careers" vacuum that currently threatens to swallow those junior doctors who are too old for a foundation programme yet too young to have secured a specialist registrar post. If this does indeed curtail all opportunities for career progression she may end up as "just" a doctor after all.

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1 Hunt T. I just wanted to be a doctor. *BMJ* 2006;333:359. (12 August.)

Medicine and its representation

Editor—Hunt captures a key dynamic in modern medicine.[1] At all levels we seem to have two jobs: firstly, to do the job and see patients, and secondly, to prove that we have done this activity, and to an appropriate standard.

Doing the job is actually the core reason for doctors to exist. It is the hardest part of medicine. Meeting and dealing well with people with all their pathology and their personal particularities is hard work. By comparison with this, going to meetings is far easier.

To do our core job, doctors have to jump through multiple hoops of audit, quality assurance, clinical governance, appraisal, and now revalidation. There is no evidence that these time consuming activities do anything for patient care. There is no evidence that they measure what matters, or reliably discriminate good practice from poor practice. Indeed I propose that in their current form they could all be stopped and that no patient would be worse off.

However, for Hunt, and the rest of us, we currently need to throw some salt on the altar of audit and worship the idols of clinical governance and research. It is now possible to make a career doing this, and so rarely see any real patients at all. But never mind the numbers, feel the depth of the evidence based quality.

Meanwhile the discharge summaries do not get written on time, and the readmission rate is going up.

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1 Hunt T. I just wanted to be a doctor. *BMJ* 2006;333:359. (12 August.)

Managing conjunctivitis in general practice

Recommendations depend on health system

Editor—The conclusions drawn by Everitt et al that delayed prescribing of antibiotics is probably the most appropriate strategy for managing acute conjunctivitis in primary care are really dependent on the health system.[1] For the outcome of interest to patients—duration of symptoms—immediate antibiotics were clearly superior to delayed or no antibiotics. Whether the outcome of interest to the general practitioner—reattendance of the patient—is superior or inferior depends on the system. In the UK system, reattendance is discouraged by general practitioners; in Australia, with a fee-for-service system, it is not.

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1 Everitt HA, Little PS, Smith PWF. A randomised controlled trial of management strategies for acute infective conjunctivitis in general practice. *BMJ* 2006;333:321. (12 August.)

Research into management strategies for acute infective conjunctivitis

Editor—Neither Everitt et al nor Rietveld et al seem to have consulted an ophthalmologist when designing their studies.[1 2] There is little evidence base to back up the clinical features of a condition that many practitioners take for granted. Ophthalmologists, in particular, are aware that adenoviral conjunctivitis tends to follow a distinct clinical pattern: patients often complain of watering and "grittiness" (initially in one eye before involvement of the other), and on closer questioning it often becomes apparent that other family members or work colleagues have had a similar problem. Pre-auricular lymphadenopathy is also a helpful sign. Symptoms may take up to three weeks to resolve, and the patient has not uncommonly been using topical antibiotics for a protracted period at the time of referral—these contain preservatives that may trigger an allergic response in an already inflamed eye, thereby exacerbating the patient's symptoms. A diagnosis of chlamydial conjunctivitis or allergic conjunctivitis is more likely to be made in intractable cases than one of bacterial conjunctivitis. In addition, given the plethora of bacterial commensals in the eye, the temptation to treat a swab result rather than the patient should be resisted.

Incorporating these key features of the patient history and examination into their analyses might have strengthened the results of both studies. Rietveld et al established that if a patient has had sticky eyes on waking then he or she is more likely to have a positive bacterial culture. This does not necessarily translate into a diagnosis of bacterial conjunctivitis. The diagnosis of acute infective conjunctivitis in the study by Everitt et al is too broad. Identifying the exact nature of the pathogen associated with specific symptoms or signs would be valuable in this context, and not particularly difficult to do.[3–5] Often it is possible to identify the cause of conjunctivitis by virtue of a good history and basic examination alone. A move away from

widespread empirical use of antibiotics for acute conjunctivitis is to be welcomed, not least because minimising patients' attendance at general practices and eye clinics should help reduce the spread of outbreaks.

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Fixing the NHS

We need fewer and better managers

Editor—Black's article embodies the problem in the NHS at the moment—a polarised position with government, Department of Health, NHS Executive, and managers often on one side, and healthcare professionals on the other.[1] To the author, anyone who criticises the current direction of the NHS is "anti-reform."

Many points in the article show the problem that management consultants have in oversimplifying the processes of the NHS—for example, I visit my inpatients every day, including weekends when not on call. But how am I to discharge them into a system where social service provision and even transport home or pharmacies are not available at the weekend? To help me discharge patients appropriately, the whole system of community care has to adjust as well.

The statement that doctors do not have the management expertise to know how to organise process well is not true. Doctors have been the driving force behind most positive developments in the healthcare environment. Hospital doctors have at least two degree level qualifications, and often three. Many also have qualifications in management or business or organisational psychology. Every day they manage an extensive multidisciplinary team, with complex and ever changing processes, deal face to face with clients—the public—in some of the most stressful situations possible. We are required to maintain competency, keep up to date with organisational as well as clinical change, and we usually achieve that effectively.

This drive, necessary educational performance, as well as at least 10 or 20 years' training, clinical skill, and understanding of how the NHS works is precisely what many politicians and managers find personally threatening and difficult to manage—and end up criticising as "conservatism" or "anti-reformist." Doctors who voice these problems are immediately criticised as arrogant or elitist—elitism being the greatest crime in the homogenised mediocrity that often seems to be the aspiration of New Labour "reform."

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1 Black S. More and better management is the key to fixing the NHS. *BMJ* 2006;333:358. (12 August.)

NHS is undermanaged, but overadministered

Editor—The NHS is indeed undermanaged, and even many of those managers have no formal management qualification.[1] So why do so many clinicians believe there are too many managers? Because, as the author points out, there is too much bureaucracy, which is performed by administrators who are called managers. If this distinction between management and administration were made explicit, and the centre demanded less bureaucracy, managers might be both recognised and rewarded for their skills. I have the excellent good fortune to work with a superb manager, and if all trusts had sufficient good managers, there would be no need for management consultants.

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1 Black S. More and better management is the key to fixing the NHS. *BMJ* 2006;333:358. (12 August.)

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Summary of rapid responses

Stephen Black's article resulted in more than 30 lively responses from general practitioners and hospital doctors, almost exclusively from the United Kingdom. Most were in agreement that what is needed is not more, but better, managers, with pertinent training suggested as a solution. Most agreed, however, that management consultants—such as the author himself—are expensive and of limited usefulness since they are not involved in the organisation. The opinions of doctors and nurses should have been sought out, said many. A couple lamented the polarisation that had occurred between clinicians and managers, which was not helping in a climate of financial and staffing constraints.

Opinions differed about whether NHS managers needed a medical qualification, but possessing an understanding of the working processes within the NHS was seen as absolutely essential. Indeed, one of the criticisms repeatedly levelled at the author was that he had displayed no such understanding: his recommendations on afternoon and weekend discharges in particular were perceived by correspondents to demonstrate this lack of insight. The NHS was seen as possessing an unmeasurable quality that management consultants, with their "obsession with the measurable" fail to grasp—targets for waiting times being a case in point, where nothing had actually improved.

Similarly hotly debated was the issue of staffing levels: the absolute necessity of more "frontline" staff was expressed by numerous correspondents (especially by doctors working in emergency medicine), not more managers or administrators at their expense. Investment in IT systems was seen as a positive future undertaking, but most pointed out the primary need to remedy the current situation and invest in staff. Several doctors reported having had some form of management training and had found this extremely beneficial in expanding their professional skills. Most were united in stating that while doctors do not necessarily make good managers, managers certainly could not do doctors' jobs, and specific training, close cooperation with colleagues, and good communication might help a new breed of "medical managers" emerge, as well as establish a common framework of management skills around healthcare delivery. Doctors are expressing a willingness to tackle management tasks and roles, with appropriate training—and what they do not want is more bureaucrats, administrators, or managers without competence. I wonder what the managers think.

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Heatwaves and hospital staff

Highest level was not reached

Editor—The editorial by Kovats raises some important issues about public health action in response to severe weather.[1] The article states that in July the United Kingdom experienced a more severe heatwave than in 2003. Although the "average" temperature for July broke all records for any month, the temperatures in 2003 were higher for longer. This distinction is recognised in the heatwave plan for England, where alerts are based on duration as well as on daytime and night-time temperature.

It is obviously very early to be drawing firm conclusions about the impact of the plan, just over two weeks after the last "level 3" in England, but we are currently carrying out a rapid evaluation. There are some signs that it may well have had the intended effects. Preliminary reports from inspectors and regulation managers in the Commission for Social Care Inspection, for example,

indicate a high level of awareness among care home managers and staff about what to do—with many homes taking special steps to keep residents hydrated, cool with fans, and out of the sun. The increase in calls related to heatstroke and sunstroke to NHS Direct was slightly less than the peak levels experienced during August 2003, and at the peak of temperatures still accounted for less than 1% of all calls. Reports of heatstroke during the hottest week amounted to only 30 cases from 460 practices.[2]

As Kovats states, vulnerable people need to be actively identified and cared for in a heatwave and this is what we have built into the plan. Kovats says there is much confusion about identifying people at risk as well as the specific advice to be given, but it is not clear on what basis she says this. Our early impressions are that some of the very specific advice in the plan has been well understood and acted on—to the benefit of some of the most vulnerable people.

She is right that we do not have real time mortality data. Improvements in the systems for handling death registration data nationally may help from next year. What data we do have for July are impossible to interpret, but at a national level variation appears to be within normal limits. Further analysis including regional age-specific analysis will be completed as soon as data become available over the next few weeks.

Kovats is also right to highlight that climate change needs to be taken into account in health protection—this is a public health challenge we must acknowledge.

This year, the heatwave plan was launched with much encouragement to those responsible for its implementation to "mainstream" it, and get it perceived in the same sort of light as the pandemic flu plan. Those individuals and organisations with responsibility for enhancing our overall resilience need to "own" the plan. Fortunately the July heatwave did not reach the highest level, level 4. In future years, it may well do so. As Kovats implies, it is not just the health service and social care that need to be prepared.

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1 Kovats RS. Heat waves and health protection. *BMJ* 2006;333:314-5. (12 August.)
2 Health Protection Agency. *QRESEARCH Bulletin* 2006;89:week 30.

Taking the temperatures may be important

Editor—We read with interest Kovats's review of the impact of the recent heat wave on public health.[1] We noticed several patients on the general surgical ward during this period with fevers up to 38°C but normal inflammatory markers. This led us to investigate the temperatures of the staff in the hospital.

We assessed the tympanic temperature, using the Kendall Genius first temp tympanic thermometer, of 21 members of staff at 830 pm on 19 July 2006, the end of the hottest day in north Wales. A few weeks later on a cold day, temperatures were taken at the same time of day from 10 further staff members. Out of the 21 temperatures recorded on the hot day, only four were normal (below 37°C). The mean temperature was 37.33°C and the maximum temperature was 37.9°C. Among the temperatures recorded on the cooler day, the mean temperature was 36.36°C and the maximum temperature was 37°C. The difference between the two samples was statistically significant using an unpaired t test ($P < 0.001$).

Although our sample sizes are small there is statistically significant evidence to show unexpectedly high temperatures in healthy staff members during the recent heat wave. This may be due to the sudden increase in temperature after a long cold winter in north Wales.

These results are important to remember when managing patients with high temperatures but normal inflammatory markers during a heat wave to avoid inappropriate use of antibiotics.

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1 Kovats RS. Heat waves and health protection. *BMJ* 2006;333:314-5. (12 August.)

Preventing postoperative nausea and vomiting

Prevention in context

Editor—Metoclopramide is one of the drugs that we reviewed in our recent Cochrane meta-analysis.[1] We also found that metoclopramide was effective. We found that, compared with placebo, the average relative risk for postoperative nausea and vomiting was 0.76 for all doses of metoclopramide, which compares to 0.89, 0.75, and 0.63 for 10 mg, 25 mg, and 50 mg of metoclopramide in the study reported by Wallenborn et al.[2] We would like to comment on the useful information that Wallenborn's study provides in this context.

Wallenborn et al provided the most information linking antiemetic dose with effect. We found a clear pattern of increasing effect in our review for droperidol, but less convincing patterns for other antiemetics, including metoclopramide.[1] Wallenborn et al did not measure a significant difference between 10 mg of metoclopramide and placebo. From our systematic review, we think that 10 mg of intravenous metoclopramide does have an effect, but not sufficient to be detected at the $P = 0.05$ level in 788 participants with a control risk of 0.23.

We included 737 studies involving 103 237 people.[1] We found convincing evidence that nine drugs were effective. But the results for all nine were skewed, probably by publication bias. The results for metoclopramide were skewed the least, as illustrated by a funnel plot that was only mildly asymmetric. As Sweeney comments in his editorial,[3] many clinicians either dismiss metoclopramide or consider it to be a weak antiemetic. This conservative expectation has probably resulted in the least distortion of effect for metoclopramide, perhaps by "allowing" the publication of studies that show little or no antiemetic effect.

We found that the funnel plots for newer agents, either in comparison with placebo or older antiemetics, were markedly skewed. We think that clinicians should be cautious, in both extolling the virtues of new antiemetics and in discarding older drugs, particularly when rare adverse reactions are detected only after a large number are exposed to a new drug.

In the United Kingdom 10 mg of intravenous metoclopramide costs about £0.27. The metoclopramide cost of prophylaxis for 1000 people would be £270 (€396; $510), £675, and £1350 at the three doses in this study. This compares to about £5990 for 4 mg of ondansetron and £8600 for 1 mg of granisetron.

Finally we disagree with Sweeney's suggestion that a head to head trial of metoclopramide and dexamethasone versus a 5-HT3 antagonist combined with dexamethasone would be the next logical step.[3] This proposed study would add little to all the other studies of metoclopramide and 5-HT3 antagonists. If clinicians remain set on more "primary" research, despite the incomplete synthesis of the research already published, they should concentrate on the detection of rare serious side effects.

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