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CARDIAC SURGERY MORTALITY RATES

A lesson in ensuring good clinical practice



The leadership shown by UK cardiac surgeons through the Society for Cardiothoracic Surgery in Great Britain and Ireland offers the best way to ensure good clinical practice for all patients in the future.¹ To understand why, it is worth highlighting the essentials of their achievement.

1. As experts in their field, they have taken collective responsibility for their clinical standards. For them, “the buck stops here.”
2. Their chosen measure of clinical outcome is at the level of the individual surgeon. That degree of granularity is essential to have confidence in the performance of every clinician. When patient experience data of comparable granularity are added, as they will be, the picture will be virtually complete.
3. They have embraced complete transparency through the publication of their results.
4. They have set the bar high, reflecting the optimal standard of practice achievable under normal operational circumstances. This “gold” standard is exactly what patients hope for.
5. The surgeons themselves took the initiatives described above because they thought it the right thing to do for patients.
6. One important consequence is that the standards of evidence and performance that they will offer for revalidation, and therefore for meaningful licensure, will be driven by conviction rather than coercion.

If every medical royal college and specialist society took this kind of responsibility for professional standards, we would go a long way towards achieving the consistency of clinical quality we all want to see in the NHS. This would also make many of the more bureaucratic recommendations in the excellent Francis report unnecessary.

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MEDICAL DEVICES

Inaccuracy of forehead thermometers

I wish to alert readers, both hospital doctors and general practitioners, to the increasing use of forehead thermometers in hospitals in the UK. These thermometers are bought because, not needing probe covers, they are cheaper. No formal health technology assessment of these devices has been performed, in the UK or elsewhere. A 2011 systematic review of the accuracy of peripheral thermometry in critically ill patients found no studies of forehead thermometers used in this context.¹

As a general practitioner, my concern arose after a patient of ours was an inpatient on a general surgical ward. She had high swinging fevers and rigors that were missed by forehead thermometry. This was because she was seriously ill with peripheral shut-down. After extensive investigation, the hospital’s medical director has reassured me that these thermometers work well, “except in critically ill patients.” This seems to me about as useful as a boiler that works only in summer.

The medical literature on peripheral thermometry is scant and, to my mind, does not warrant a wholesale change from tympanic thermometry. A good correlation between peripheral and tympanic thermometry has been reported in children,² but authors have reported a poor correlation in adults and decreased accuracy with age.³ All peripheral sites—tympanic membrane, forehead, and axilla—are imperfect; oral and rectal thermometers are more accurate; a pulmonary artery catheter is the gold standard.⁴ I recommend a halt for evaluation before any more forehead thermometers are bought. Where hospitals have bought them, staff should be made aware of their limitations, and an alternative method of measuring core temperature should be available in each clinical area.

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INCIDENTAL THROMBOCYTOPENIA

Test for HIV if indicated, regardless of risk factors

Bradbury and Murray list HIV infection as a cause of thrombocytopenia in asymptomatic patients and include HIV testing in their list of suggested investigations,¹ although they favour limiting testing to patients with identified risk factors.

Isolated abnormalities in the full blood count (thrombocytopenia, anaemia, neutropenia, and lymphopenia) are clinical indicators of HIV infection and can be the first presentation in a patient with a normal CD4 count. In the presence of a clinical indicator, diagnostic testing for HIV is appropriate, regardless of risk factors, and an HIV test should be requested.²

HIV testing is relatively cheap (around £10; €11.7; \$15.2). An early diagnosis can prevent serious long term morbidity and death. Those diagnosed late (CD4 count <350×10⁶ cells/L) have a 10-fold increased risk of dying within a year of diagnosis. In 2011, 47% of patients were diagnosed late.³

A letter from the chief medical officer in 2007 highlighted best practice around HIV testing and the importance of testing in all healthcare settings.⁴ Lengthy pretest counselling is not a requirement unless requested by the patient.

If the differential diagnosis includes HIV infection, HIV testing should not be limited to people with identified risk factors. In addition to non-disclosure, a growing number of infections occur in heterosexual men and women—48% of new diagnoses in 2011 were in heterosexual

men and women, half of whom were infected in the UK.³

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PULMONARY EMBOLISM

Use of surgical embolectomy

Pulmonary embolism remains a major healthcare burden and some patients still die from this preventable disease, perhaps because of limited knowledge about available treatments for massive pulmonary embolism.¹

Systemic thrombolysis has been the mainstay for massive pulmonary embolism. Other options include transcatheter clot removal and locally directed thrombolysis, but their application is limited by availability of local expertise and absence of long term outcome data. Surgery, barely considered by many clinicians or in Takach Lapner and Kearon's review, is another option.^{1 2} Long term survival and functional outcome after surgical embolectomy are encouraging.³

Surgery has clearcut indications in massive pulmonary embolism, including patients in whom thrombolysis is contraindicated, those with a large right atrial or ventricular clot, and those with a clot lying across an interatrial foramen. However, perhaps the most important indication is in patients who do not respond to thrombolysis. Many perceive surgery to be impossible in this setting. Although the ensuing coagulopathy can be a problem, requiring skilled haematological input to reverse it, many of these patients will die without intervention. If operated on before cardiac arrest, current mortality is just over 10%.² Evidence also suggests that surgery gives a better outcome than repeat thrombolysis.⁴ Finally, the review also overlooked the potential of stabilisation with extracorporeal membrane oxygenation for acute unstable massive pulmonary embolism.⁵

To reduce mortality in patients with acute massive pulmonary embolism, frontline clinicians need greater awareness of the potential benefits of surgery and direct lines of communication with surgeons familiar with the procedure.²

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ACCEPTABLE FACE OF BIG PHARMA?

Only time will tell

The timing of your profile on Andrew Witty is somewhat bemusing.¹

Certainly, GSK's recent moves have been exciting. Simply signing up to the alltrials.net campaign is a huge step for such a large drug company, and we can only hope that this will shame other companies into taking similar action.

But your article misses two important points. Firstly, we have seen this all before. Time and again drug companies have promised to publish data, only to drag their feet. This is true of Roche, and it was true of GSK in the rosiglitazone scandal, which overlaps with Witty's tenure as executive officer.^{2 3}

Secondly, we should not look to a member of industry to prevent the transgressions of the past occurring again. Stopping big pharma from partaking in fraudulent activities, hiding trial data, or promoting drugs inappropriately must be the role of regulators and the legal system, not the whims of whoever happens to be in charge.

If we ever do see real action—all of GSK's clinical trial data being available in an accessible analysable format—then it might be appropriate to portray an industry leader on the front cover of your journal as a symbol of hope for our profession.

Until that day, we should withhold our praise.



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AN UNSAFE WARD

Separation of basic and nursing care may be to blame

I have received more than 30 supportive comments on my article about the death of my father.¹ Many people were not surprised by my experiences and described their own sad stories. This suggests that poor basic care for older patients is endemic within the NHS, with mid-Staffs just a scapegoat for a widespread institutional malaise.

Food, water, cleanliness, and simple human kindness are cheap and effective treatments for older inpatients. The modern NHS seems to have separated the concepts of basic and nursing care; catering services are part of basic care and have been subcontracted out to private companies, so nurses may no longer see eating and drinking as "their responsibility." This fragmentation may explain some of the problems. But expensive interventions and treatments are wasted unless the basics for human life are supplied.

Useful suggestions on how to deal with the problem included the "butterfly scheme" (www.butterflyscheme.org.uk/) and "intentional comfort rounding,"² but neither has been evaluated scientifically. Evaluating projects that could reduce suffering and harm in NHS hospitals should be a priority.

The suggestion that relatives could help with basic nursing care was recently endorsed by the think tank 2020health.³

The core of any change needs to be with nursing culture and practice. All clinicians need to feel able to challenge and improve poor standards without blame or reproach. I hope this is recognised before many more elderly patients die unnecessarily.

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