

LETTERS

Letters are selected from rapid responses posted on thebmj.com. After editing, all letters are published online (www.bmj.com/archive/sevendays) and about half are published in print
▶ To submit a rapid response go to any article on thebmj.com and click “respond to this article”

UK ACADEMIC GENERAL PRACTICE

Research and teaching in general practice/ primary care



Campbell and colleagues note that GP academics comprise just 6.5% of all clinical academics.¹ General practice is the biggest branch of medicine. It has a variety of clinical challenges that cross the physical-psychological barrier, it best integrates preventive and therapeutic care, and is best able to ameliorate socioeconomic disadvantage. The ratio of 205 full time equivalent GP academics to 32 628 full time equivalent GPs (1:159) is much worse than in specialist practice. This 6.5% figure is a public failure by UK medical schools collectively.

Some medical schools send students into general practices without teaching the theory of general practice; they leave GP teachers without a GP curriculum and do not tell them what has been covered previously. The two newest UK Medical Schools—Exeter and Plymouth—do not even give students a general practice reading list. Both these medical schools have had their curriculums commended by the GMC. However, because the membership of the GMC does not include a single GP,² it may not be competent to consider medicine outside hospital or to guide medical schools and medical students appropriately. The non-verbal message from the GMC and these medical schools to medical students is that general practice is unimportant, and that nothing future doctors need to read has ever been written about or by GPs. The purpose of medical schools is to produce the doctors that the nation needs. Despite good research in the UK, like the US,³ medical schools are currently failing their main function.

Recently, the student GP society in the Exeter Medical School requested a general practice reading list, which the Tamar faculty of the Royal College of General Practitioners has constructed.⁴

Denis Pereira Gray emeritus professor and consultant, St Leonard's Research Practice, Exeter, Exeter EX2 4TJ, UK
denis.pereiragray@btinternet.com

1 Campbell J, Hobbs FDR, Irish B, et al. UK academic general practice and primary care. *BMJ* 2015;351:h4164. (31 July)
Cite this as: *BMJ* 2015;351:h4737

NICE ON SAFE STAFFING

Basing safe staffing levels on evidence

I was not surprised that the National Institute for Health and Care Excellence (NICE) was asked to suspend its guidance on safe staffing,¹ because this guidance is another example of the inflationary pressure NICE can place on the NHS by limiting its health economic analysis to cost effectiveness and not cost impact.² This view was recently taken by Monitor when it urged trusts to follow guidelines on safe staffing in a way that was “proportionate and appropriate.”³

I was surprised, however, to read that NICE had abandoned plans to publish four evidence reviews of safe staffing in other settings, including mental health and community nursing.⁴ Apparently, the reason is to avoid pre-empting future work on safe staffing by the new regulator NHS Improvement (formed by the merger of Monitor and the Trust Development Authority). This is another worrying example of policy makers choosing to ignore awkward evidence, and it reflects a growing trend away from evidence based policy just when it is needed most. The public paid for the research so they deserve to see it.

Peter Littlejohns professor of public health, Faculty of Life Sciences and Medicine, King's College London, London SE1 3QD, UK
peter.littlejohns@kcl.ac.uk

4 In brief. NICE backtracks on plan to publish safe staffing guidance. *BMJ* 2015;351:h4219. (5 August.)

Cite this as: *BMJ* 2015;351:h4556

PATIENTS AND TRIAL ENROLMENT

Flexibility in trial enrolment decisions

Dickert and Miller debate patient consent in acute myocardial infarction trials.¹

We randomly allocated critically ill patients with an admission diagnosis of ruptured abdominal aortic aneurysm to endovascular repair or open surgical repair.² Of the 652 patients approached for initial brief consent, 42 (6.4%) refused because they had a preference for no treatment or for a specific

treatment. Six hundred and thirteen patients were randomised, 509 (83%) of whom provided brief witnessed verbal or written consent. A relative or carer provided consent for 44 (7%), and 60 (10%) were randomised using the Mental Capacity Act, with a clinician from outside the immediate management team confirming that this route was appropriate. For patients who survived until discharge, further full consent was obtained, and at this point 6/384 (2%) patients refused consent.

It seems important to allow patients the option of immediate consent whenever possible (in our experience nearly all agree to participate) and to allow them to reconsider this decision when their health has improved. This type of flexible arrangement could also be used in acute myocardial infarction trials.

Janet T Powell professor
j.powell@imperial.ac.uk
Pinar Ulug clinical trial manager, Charing Cross Hospital, Imperial College London, London W6 8RF, UK

1 Dickert NW, Miller FG. Involving patients in enrolment decisions for acute myocardial infarction trials. *BMJ* 2015;351:h3791. (29 July.)

Cite this as: *BMJ* 2015;351:h4608

FREE WI-FI ACROSS THE NHS

Wi-fi is essential for medical education and for safe care

We disagree with several of Ingram's assertions.¹ As clinical teaching fellows working primarily in undergraduate medical education, we think that access to wi-fi is a necessity, not a luxury. It is also in keeping with recently published General Medical Council guidance.² Our students use personal handheld devices to access clinical guidelines, to use teaching materials, and for academic administration. With many major scientific publications appearing exclusively online, and textbooks often becoming outdated before they leave the printing press, it's unhelpful to deny NHS staff and students access to up-to-date resources through wi-fi.

As NHS finances become increasingly stretched the utility of rapid, effective, time sensitive communication becomes ever more apparent. Wi-fi facilitates mobile email access, an essential part of the professional

lives of most students, doctors, and other healthcare professionals. Reliable wi-fi also enables the use of voice-over-internet-protocol (VOIP) telephone communication, which offers comparable quality to traditional telephone services at hugely reduced costs.³

Presumably filtering and authentication software would be needed to implement wi-fi in NHS premises. Filtering and other security software are readily available and are already being used by most NHS organisations for wired internet access.⁴ The Eduroam network provides authentication for academic internet access across thousands of institutions around the world,⁵ and it could surely be adapted for use within NHS institutions.

Wi-fi access is necessary to drive increased efficiency and promote patient safety in healthcare institutions.

Scott W Oliver clinical teaching fellow
drscottoliver@gmail.com

Kathleen Collins clinical teaching fellow, NHS Lanarkshire, Postgraduate Office, Wishaw General Hospital, Wishaw ML2 0DP, UK

1 Betton V, Ingrams G. Should all NHS premises provide free access to wi-fi? *BMJ* 2015;351:h4098. (12 August.)

Cite this as: *BMJ* 2015;351:h4642

COMPLEX REGIONAL PAIN SYNDROME

CRPS must be recognised early in children

Complex regional pain syndrome (CRPS) in children and adolescents is often missed, with lengthy delays before appropriate treatment is started.¹ This may be because of clinicians' lack of awareness or the heterogeneity of the presenting signs and symptoms, although paediatric presentation has several unique features when compared with adults (table). Whatever the underlying cause, such delays mean that paediatric patients are often evaluated by a spectrum of specialists and undergo unnecessary diagnostic investigations and lengthy immobilisations. Consequently, many of these patients present to children's chronic pain services late after the onset of symptoms and with increased pain levels and severe functional disability.

After appropriate treatment, which centres on active remobilisation, the prognosis of CRPS in children is excellent. However, like all chronic pain conditions in childhood, a comprehensive, biopsychosocial, and multimodal approach to evaluation and management is needed.² Active physiotherapy, desensitisation, muscle strengthening, and restoration of normal extremity function form the cornerstone of treatment.³ Psychological interventions are often used to deal with contributing cognitive, affective, behavioural, social, and family

Differences in presentation and outcome between paediatric and adult complex regional pain syndrome

Factor	Children	Adults
Sex	Female>Male	Female>Male
Extremity affected	Lower	Upper
Precipitating trauma	Mild or none	Severe
Vasomotor symptoms and signs:		
Temperature and colour changes	Severe	Moderate
Motor or trophic symptoms and signs:		
Limited range of movement	Moderate	Severe
Tremor	Mild	Moderate
Skin and nails	Mild	Moderate
Psychological functioning	Severely affected	Mild/moderate
Functional outcome	Very good	Moderate
Recurrence rates in the same or other locations	High	Moderate

dynamic factors and to facilitate return to developmentally appropriate activities.

Neuroimaging studies show a rapid alteration in global brain networks and return to the previous state after interdisciplinary rehabilitative treatment, suggesting that the higher chance of recovery typically seen in children compared with adults is probably due to enhanced CNS plasticity during childhood and adolescence.⁴⁻⁵ Thus, a focus on early recognition and intensive interdisciplinary rehabilitation is needed in young people with CRPS.

Christina Liossi senior lecturer in health psychology, School of Psychology, University of Southampton, Southampton SO17 1BJ, UK c.liossi@soton.ac.uk
Jacqui Clinch consultant paediatric rheumatologist, Bristol Royal Hospital for Children, University Hospitals Bristol NHS Foundation Trust, Bristol, UK
Richard Howard consultant in paediatric anaesthesia and pain medicine, Great Ormond Street Hospital for Children NHS Foundation Trust, London, UK

1 Bruehl S. Complex regional pain syndrome. *BMJ* 2015;351:h2730. (29 July.)

Cite this as: *BMJ* 2015;351:h4748

COMPASSION

Nurturing compassion

Chadwick is only partly correct.¹ There is something ineffable about compassion, so attempts to force it on staff will probably be clumsy and counterproductive, but it shouldn't be left at this.

We know quite a bit about the effect of different situations on human relationships and that ordinary people can behave callously, cruelly, or abusively under certain conditions.²⁻⁴ Although it is unclear exactly how this happens,⁵⁻⁶ if the NHS wishes to create situations in which compassion thrives, it must

avoid overwork and understaffing and a culture in which powerful figures preferentially reward non-clinical organisational goals. It must also strive to overcome the "them and us" hostility between staff and patients.

We also know that good care can flourish in the unlikely of places. Patterson and colleagues report on an "enriched ward" existing in the midst of a failing trust, probably as a result of the ward manager's strong leadership.⁷ To change the culture in clinical care we need to invest seriously in leadership at staff nurse and ward manager level⁸—these are the people who can make a Mid Staffordshire event less likely to occur again.

Paul Whitby clinical psychologist, Avon and Wiltshire NHS Mental Health Trust, Green Lane Hospital, Devizes SN10 5DS, UK
paul.whitby@nhs.net

1 Chadwick R. Compassion: hard to define, impossible to mandate. *BMJ* 2015;351:h3991. (29 July.)

Cite this as: *BMJ* 2015;351:h4600

Compassion can be learnt and must be integrated into practice

The word compassion is often heard in connection with care provided by health and social care professionals but often without the thoughtful attitude seen in Chadwick's article.¹ We have previously suggested that compassion is in danger of becoming a jargon term and, as a result, losing some of its power.²

Frontline care workers need training and support in recognising and coping with the range of feelings—positive and negative—engendered by some people they have to care for. It has long been recognised that these feelings are highly relevant to quality of care and are ignored at our peril.³ People working in caring roles need to know that it is OK to feel powerful negative feelings, such as disgust, impatience, and even hatred, but that they must find strategies and resources within themselves not to act on these feelings.

We need a more open dialogue about fostering compassion. As Chadwick suggests it can't be prescribed, but it isn't a happy extra that is wonderful when it happens. We believe that it can be learnt and must be integrated into practice.

Susan Maciver convenor, adult counselling service
Chris McGregor counsellor
Jenny Robertson member
Tom C Russ member
tom.russ@nhslothian.scot.nhs.uk
Christine Wilson organisational consultant, Working with Older People Steering Group, Human Development Scotland, Edinburgh EH3 8EB, UK
On behalf of the Working with Older People Steering Group

Cite this as: *BMJ* 2015;351:h4602