

THE DISCHARGE SUMMARY AS A MEDIUM FOR TEACHING AND LEARNING

The decline in bedside teaching¹ should cause the most profound disquiet when a diagnosis is missed as a result of suboptimal performance of what ought to be a routine clinical examination. This was the case in an 85-year-old woman in whom the clinical clue to the diagnosis was a palpable thrill which was missed by >25 physicians who had previously examined her.²

Unfortunately, for some of those doctors, the opportunity did not arise for them to reflect on their own lapse in performance so as to inform the quality of future patient care. In hospital medicine, however, and for the junior doctor in his formative years of apprenticeship, an opportunity to reflect on lapses in performance is generated by the occasion to compose a discharge summary.

Therefore, over and above its use as a medium of communication between secondary care and primary care, the discharge summary also deserves to be recognised as a strategy for reviewing the clinical decision process and for identifying ‘teachable moments’ which should inform future patient care.

Teachable moments which recur from time to time, potentially posing a threat to the patient, include missed diagnoses, diagnostic delay, inappropriate investigations, inappropriate medications and ‘near misses’. Accordingly, far from being a peripheral activity involving only the most junior members of staff³ the discharge summary should be a key ingredient of departmental activity, justifying audit in its own right. Audit meetings in which the discharge summary is the subject matter should be chaired by a senior clinician, and the participants should include medical as well as paramedical staff. In other words, by raising the profile of the discharge summary we ensure the patient remains at the centre of teaching and learning, even when he or she is no longer in our midst.

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A WAKE-UP CALL?

The editorial by Elder and Verghese¹ should function as a wake-up call for medical educators. The situation may be somewhat worse than they surmise.

Teaching of medical students often assumes that clinical exposure to textbooks, guidelines and the internet are of paramount importance and that brief patient contact in teaching sessions will compensate for reduced patient contact. There is little continuous personal involvement with patients.

Students need to know there is more to medical life than knowledge derived from textbooks and guidelines. In reality, patients these days are older, often with multiple pathologies, and textbooks and guidelines tend to be derived from reductionist information derived from studies on selected patients who have a single uncomplicated condition.² Weighing up advice derived from conflicting guidelines is not easily taught to undergraduates. The challenge is to make students think so they can navigate through this maelstrom of advice.

There is some hope. There are some students and doctors in training who are angry and will hold us to account especially when they are paying for their tuition. They complain of lack of mentorship as they are processed on what seems to them like a production line. Times and tides are changing and I fear a tsunami of discontent involving undergraduates and doctors in training.

Both undergraduate and postgraduate students need to be encouraged to scan through general medical journals to see what is new, interesting or controversial and thus memorable. In particular they should read the letters which often provide insights into previous papers. Students should do all the journal quizzes they can to gain ‘experience by proxy’, and they should look at job advertisements to see what opportunities are likely to be available to them in future.

Who should do most undergraduate teaching? I suggest a more rounded student experience should be delivered by generalists both in hospital and in general practice; A&E doctors, acute medicine doctors, general physicians, acute receiving care of the elderly physicians, and infectious diseases physicians who see almost everything (Welsby, personal observation). Some tertiary referral hospital specialists are often, I suspect, unsuitable teachers for patients with general medical multiple pathology.

Elder’s and Verghese’s conclusion was that doctors should ‘spend more time at the bedside... where the patients are’. I suspect they are more correct than

they realise. Patients these days are usually also at the bedside, sitting out beside their 'thrombosis and embolism encouraging' beds. And who teaches students the art of examining patients who are in a chair?

Since retirement Edinburgh University has employed me to teach fifth year and resit medical students. Why are more retirees not recruited to pass on the baton of medical expertise and relieve the pressure on time committed medical workers?

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GIANT CELL OR TEMPORAL ARTERITIS?

I agree with Croft et al. that colour duplex ultrasound and temporal artery biopsy are complementary investigations in the diagnosis of giant cell arteritis (GCA), but arterial biopsy remains the most specific diagnostic procedure.^{1,2} GCA is defined by the presence of giant cells though frequently, but not always, observed in biopsy specimens from patients with active disease.² Hence the term GCA should only be used if the biopsy shows positive histopathologic changes of arteritis, either granulomatous lesions, usually with multinucleated giant cells, or diffuse mononuclear cell infiltration, and the term temporal arteritis, though its use is discouraged by the International Chapel Hill Consensus Conference Nomenclature of Vasculitides, is preferred if the diagnosis is made on clinical grounds and/or using colour duplex ultrasound without a biopsy.^{2,3} In addition, temporal arteritis can occur in patients with systemic vasculitis without classic GCA. Non-GCA, such as necrotising vasculitis, polyarteritis and 'hypersensitivity' angiitis, have been reported to involve the temporal arteries.^{2,4,5} The prognosis of those patients with non-GCA may be less favourable if corticosteroids are used as the only agents, and additional immunosuppressant drugs are often needed.

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Authors' reply

We thank Professor Jawad for his interest in our work and are pleased to note that he agrees colour duplex ultrasound (CDUS) and temporal artery biopsy (TAB) are complementary tests. Jawad recommends that the term giant cell arteritis (GCA) is only used if biopsy changes are evident and that the term temporal arteritis (TA) is used if diagnosis is made on clinical grounds. We do not agree for several reasons.

We agree that TAB offers the possibility of a definitive pathological diagnosis¹ and are aware that other conditions may cause temporal artery inflammation. Unfortunately, TAB is inadequate as a reference standard for the diagnosis of the clinical syndrome that is well understood by clinicians to be GCA. TAB has a poor diagnostic sensitivity and as a result does not produce error free classification of disease.² Biopsy negative GCA is well recognised. In addition, recent data from the TABUL trial have shown significant inter-observer variability in the interpretation of TAB histology especially when there is an absence of giant cells.³ TAB is often negative due to prior glucocorticoid use, segmental inflammation or suboptimal biopsy specimen. As a result of these limitations a negative TAB has been shown to rarely inform clinical practice.

We chose not to use the term TA because typical clinical disease may occur in the absence of temporal artery involvement. The term TA implies a rather restrictive disease distribution, when in reality this is not accurate. We prefer the term GCA as it is widely understood by the medical community, though our use of this term was not intended to imply that this pathology was found in patients.

There are no agreed diagnostic criteria for GCA and the 1990 ACR criteria and Chapel Hill consensus criteria^{4,5} were developed to differentiate different forms of vasculitis and function poorly when used diagnostically.⁶ This is because symptoms that are common have a poor predictive value for histological diagnosis and those clinical findings with a good prediction occur only rarely.

On the basis that CDUS could replace TAB in some situations, described in our paper, and given that sonographic changes of vasculitis may be seen in

arteries other than the temporal arteritis, it would seem more sensible to take a pragmatic approach to nosology.

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