

Letters to the editor

Conflicts of interest for medical practitioners

The recent editorial on conflicts of interest (Col) in academic publishing covered many important issues in publishing and research.¹ The authors rightly cover issues such as financial gain from publication, objectivity in assessing the research of others and the responsibility of editors.¹ However, the same principles are also relevant in clinical practice and medical education, and many doctors straddle multiple spheres.

Doctors must always uphold the highest professional standards, as any undermining of trust by patients in the medical profession would be hard to redress. Members of the public must not feel that doctors are acting in the interests of commercial or other organisations rather than putting their needs first. It is incumbent on doctors to declare any support they receive,² and it is likely to become compulsory in the future in all clinical and academic activities.

When journals first started to publish potential Col, these were clearly accessible, usually at the end of a manuscript. Now potential Col are often found in supplementary material or online and are less explicit. What links authors have should be upfront in any manuscript, including those relating to research.

Declaring Col when being involved in the development of clinical guidelines is mandatory, when the principles of transparency, proportionality and consistency are key.³ Individuals in a position to best develop or advise on clinical guideline development, given their expertise and background, may have significant links arising from research, with industry, patient groups or other organisations. Guidelines need to be informed by those who are experts but not influenced by commercial or other connections. There is no one size fits all, but it can and should be managed.^{4,5} However, precluding an author of a recent review paper on a topic related to the guideline from being involved may be overly restrictive, unless there are others equally qualified to contribute.⁴ An exception might be to exclude an author of a manuscript sponsored by a commercial organisation.

There are benefits to doctors having links with industry and outside organisations that can inform research, and contribute to the delivery of healthcare. However, these links must be appropriate, ethical, transparent, declared and appropriately managed, e.g. an individual is precluded from being involved in major decision-making, where a clear and potentially compromising link is present. Nonetheless, doctors need to be vigilant to ensure that they do not compartmentalise an activity in one area, e.g. research grants received from industry, and not declare these when, for example, advising on local prescribing.

If the medical profession does not continue to remain vigilant and declare Col in all areas of professional and academic practice, there will be further regulation. This in turn may stifle innovation and impair the development of mutually beneficial relationships between medical doctors and others.

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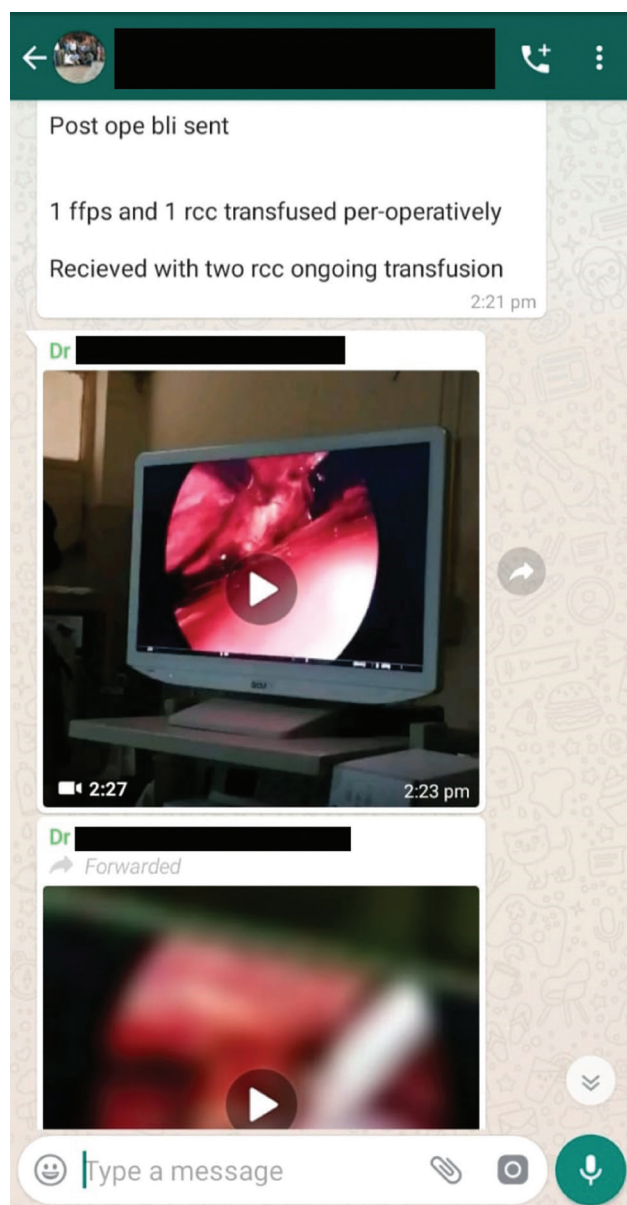
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- 5 Humphreys H, MacLellan K. Principles for disclosure of interest and management of conflicts in guidelines: desirable and undesirable action and consequences. *Ann Intern Med* 2016; 164: 701.

WhatsApp groups: an effective way of intradepartmental and interdepartmental communication regarding patient consultations

WhatsApp is a very useful mobile messaging app that is commonly used by many people around the globe. It is a way of electronic communication in which calls, messages, pictures, videos and voice messages can be sent and received by individuals or groups of people.¹ Recently, a new trend of making a WhatsApp group for different departments in our hospital has started. It has proven to be a very effective way of communication as patients' brief clinical history, examination findings and investigation can be shared with different consultants or doctors on board for planning an effective treatment regime of that patient (Figures 1 and 2). The problem relating to patient management can be addressed and discussed. It also provides a platform to share the photographs of clinical findings and investigations, such as X-ray, CT scan, MRI, etc., for an expert opinion. Status of serious patients in the ward can be updated and their management can be checked by seniors and required treatment be updated accordingly. Operative findings and procedure details can be visualised by different consultant surgeons so that an effective surgical treatment plan be made. Akoko et al.² have described the importance of instant photo and video sharing for hydrocele repair surgeries. Kopal et al.³ have described WhatsApp as a free, simple and practical application that has proven very beneficial

Figure 1 An intradepartmental and interdepartmental communication WhatsApp group being used for patient consultation

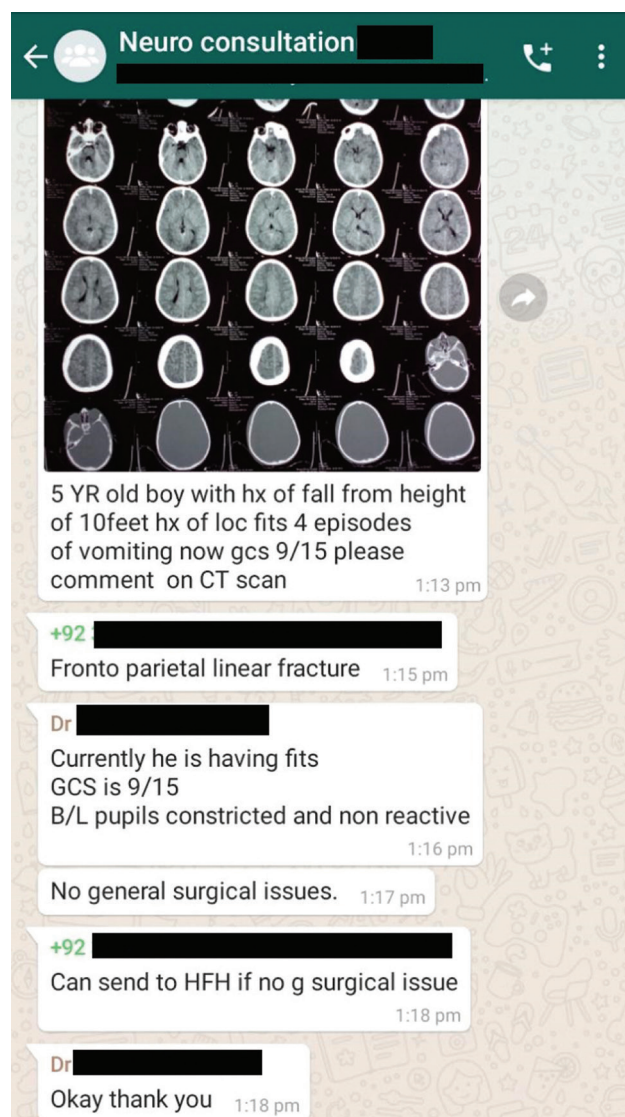


in improving communication among oral and maxillofacial surgery team.

WhatsApp groups have the potential to be useful for both patient care and administrative purposes, such as a departmental roster can be shared with every individual and attendance of staff can thus be insured, and problems in the ward can be addressed with photographs and videos. It also provides a platform in which the head of the department and all other doctors of the ward can be kept well-informed of important activities happening in the ward.

Although, sharing information on WhatsApp can be beneficial for patient care, this may compromise patient privacy and confidentiality. Due care must be taken, informed consent should be obtained and patients should be assured that their

Figure 2 An interdepartmental communication WhatsApp group being used for patient consultation



information is in safe hands. Proper guidelines regarding the sharing of patient information on WhatsApp are required. The flow of information should be controlled and only concerned doctors or paramedical staff should be added to those groups.

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Understanding the cholesterol and cytokine network in patients with adrenal insufficiency and cirrhosis

The paper by Nandish et al.¹ mentions a blunted pituitary response to circulating cytokines as a possible cause behind adrenal insufficiency in decompensated cirrhotic patients. It is likely that multiple factors are at play, such as the increased proinflammatory (Th1 type) cytokines that overstimulate and exhaust the hypothalamic-pituitary axis (HPA), increase eosinophil levels or provide unsolicited negative feedback at the HPA axis and coagulopathy in end-stage liver disease that ultimately destroys the adrenal glands.² If simply put, the important substrate required for steroidogenesis is cholesterol and in cirrhotic patients this is low, therefore, not surprisingly low high-density lipoprotein (HDL) was a consistent factor that predicted the development of adrenal exhaustion in most studies.²⁻⁴

As the adrenal gland does not store cortisol, the body relies on substrates for continuous generation of cortisol (80% is derived from HDL cholesterol, 20% from acetate and other precursors), but in cirrhosis or sepsis with underlying cirrhosis, total and HDL cholesterol levels decline rapidly and can take about 28 days to recover.⁵ Hepatic cell lines when exposed to proinflammatory cytokines, such as tumour necrosis factor- α , interleukin-1 β (IL-1 β) and IL-6, showed decreased synthesis of apoproteins (apolipoprotein A1 being precursor to HDL and inhibits proinflammatory functions of monocytes).⁶ Whether HDL infusions should be used in reversing adrenal insufficiency in these patients remains a contentious issue.⁷

The authors point out the limitation in their paper is that they used total cortisol to define adrenal insufficiency rather than free cortisol or cortisol-binding globulin, but if cholesterol level (total cholesterol or HDL cholesterol) or cell counts were incorporated into a different model for end-stage liver disease (MELD) scoring system, such as MELD-Na or MELD-PLUS,⁸ extra predictive factors could have been found to understand adrenal insufficiency in the context of decompensated liver cirrhosis that lead to worse outcomes. The role of HDL-associated apolipoprotein A1 in modulating inflammatory responses is only beginning to be understood, and perhaps relative adrenal insufficiency in cirrhosis is not only about cortisol but also controlling the cascade of events that ultimately fatigues the adrenal gland and leads to multiorgan failure.

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A return to forms: why the paperwork crisis matters

What is something that occupies most of a newly qualified doctor's day and something most medical schools fail to prepare you for? The government's own estimates put up to 70% of a FY1/2's day involving paperwork:¹ writing notes on the ward round, preparing discharge letters and to take out (TTO)/to take away (TTA) forms, and sending referral letters. Even on call or working nights, paperwork still takes up a disproportionate amount of time. Around 40% of juniors think that excessive paperwork poses a serious risk to patient safety;² perhaps the last true unifying topic of conversation between all doctors is how the 'paperwork crisis' got out of hand.

I, like many juniors,³ felt largely unprepared for the burden of paperwork on my daily life; but the importance of these mundane tasks did not truly occur to me until one horrible epiphanic moment.

At the end of a stretch of on calls, I received a fast bleep to a cardiac arrest, my first one outside of normal working hours, and when I arrived, it is chaos. No amount of simulation sessions can truly recreate being the first doctor arriving to a cardiac arrest; it is overwhelming. Nurses are shouting and performing compressions, with alarms going off in the background. Thankfully a very experienced nurse consultant had already taken charge over the defibrillator, and the responsibility of figuring out what happened fell to me. Scanning through the poorly organised paper notes whilst the rest of the team arrive, my heart drops; this patient was not for CPR. Or, at least, they were not meant to be.

It is not infrequent, due to the severe time pressures, to have patients arrive from the emergency department either without 'mandatory' treatment escalation plans (TEPs) completed, or with completed TEPs but without signed coloured DNACPR forms, the actual legal framework for DNACPR in my trust. Most of the time, this is rapidly corrected on the wards, but sadly the patient had been transferred out of hours. It was only after the patient went through several unnecessary

cycles of CPR that the registrar arrived, and a decision could be made to sign the correct form.

This is nobody's fault. Medicine is busy, and the paperwork does feel endless; but a single form would have made a difference in the case of this patient. This might be an extreme example, but it is not an isolated issue. Paperwork may be considered to be mundane, but it is important, and it is likely the most important thing FY1/2's do. The 'paperwork crisis' needs addressing, but we cannot lose sight of the vital decisions and patients beneath it.

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In memoriam

In memoriam brings to the attention of Fellows and Collegiate Members the deaths of colleagues and friends. Obituaries paying tribute to the life and work of those whose deaths have been reported in *In memoriam* can be found on the College website: www.rcpe.ac.uk/obituaries

Fellows and Collegiate Members are invited to provide the Obituaries Editor (editorial@rcpe.ac.uk) with information that will enable us to write or commission obituaries. Self-written obituaries to be held in readiness by the Obituaries Editor will always be welcome.

Dr MV Miles FRCP Edin

Born: 24/03/1932 Died: 24/12/2019

Specialty: Paediatrics/Community Child Health

MB Lond 1955, DCH Lond 1957, MRCP Edin 1963

DR IS Macdonald CB FRCP Edin

Born: 14/07/1927 Died: 04/01/2020

Specialty: Public/Community Health/Epidemiology

MB Glasg 1950, DPH Glasg 1955, MD Glasg 1958, MRCP Edin 1978, Cap III, 5

Dr BJ Weller FRCP Edin

Born: 28/08/1961 Died: 01/11/2019

Specialty: Neurology

BSc SA 1982, BM Flinders 1992

Dr C Brough FRCP Edin

Born: 04/01/1932 Died: 23/12/2019

Specialty: Public/Community Health/Epidemiology

MB Edin 1956, DPH Edin 1965 DIH Lond 1965, MRCP 1981, CAP III, 12

Dr JS Grimshaw FRCP Edin

Born: 22/09/1934 Died: 23/05/2019

Specialty: Psychiatry

MRCS Eng, LRCP Lond 1958, DPM 1962, MRCP Edin 1964

Dr AA Qazilbash FRCP Edin

Died: 01/02/2015

Specialty: General Internal Medicine

MB Punjab 1955, MRCP Glasg 1965, MRCP Edin 1966 Resp & Tub

Dr PL Chin FRCP Edin

Born: 09/05/1941 Died: 04/01/2020

Specialty: Geriatric Medicine

MB Lond 1966, MRCP Edin 1968

Dr CA Jencks FRCP Edin

Born: 21/06/1939 Died: 01/10/2019

Specialty: Non-Medical (Architect)

BA Harvard 1961, MA Lond 1965, PhD 1970, DSc Edin 2005, DLitt Glasg 2005

Professor JR Lawrence FRCP Edin

Born: 01/09/1930 Died: 27/02/2018

Specialty: Renal Medicine

MB Adelaide 1954