doctors to hinder and encourage learning and teaching opportunities on post-take ward rounds. Ward rounds have always been an essential part of postgraduate medical education since first described in 1660.¹ In the mid-1980s a survey reported that 58% of senior house officers' learning occurred on ward rounds.² However, medical education has been turned on its head in recent years with the adoption of the European Working Time Directive and the implementation of Modernising Medical Careers and the foundation year (FY) programme. In a recent study I found that only 18% of FY doctor learning occurs on ward rounds and I suspect that the issues outlined by Dewhurst play a major role in this decrease, noticeably, reduced time, reduced team cohesion and lack of awareness of learning and teaching skills.

I disagree with two commonly held views on how to improve ward-based teaching, the first is that all doctors should be teachers and therefore should learn teaching skills. There is no doubt that all experiences can provide an opportunity to learn, even the bad ones but, suggesting that all activities should have a focus on education, or an element that is taught, is an inefficient way of using a sparse resource. In the case of post-take ward rounds I believe there should sometimes be a focus on 'getting the work done', and at other times emphasis on teaching, as the most inefficient ward rounds are those in which the focus is placed on teaching but there is simply too much 'service provision' to allow learners to focus and absorb their experiences.

Teaching, like all specialties, is a skill that few are excellent at, most are reasonable at and some are terrible at. The challenge is identifying those who are good at teaching, and then promote their education activities by providing the time, recognition and financial reward that will encourage them to pursue this rapidly evolving area.

ANDREW CLARIDGE
Medical Education Fellow
Wessex Deanery

References

- 1 Baron JH. The first teaching ward round: Leyden 1660. *BMJ* 2006;333:483.

- 2 Grant J, Marsden P, King RC. Senior house officers and their training. 2. Perceptions of service and training. *BMJ* 1989;299:1265–8.

Intermediate care for older people in the UK

Editor – I welcome Woodford and George's recent journal article (*Clin Med* April 2010 pp 119–23). Older people represent the fastest growing sector of the population in the UK. Health and social care design is of paramount importance not simply because of the burgeoning cost, but because how we treat the frailest and most vulnerable in society is the barometer of developed countries whose human cost can be measured in disability, morbidity and death.

Woodford and George's article highlights that 'failing to plan is planning to fail' as the wholesale national investment in healthcare policy without an adequate evidence base is resource put at risk. The clear message is that healthcare systems that are centrally managed and funded must show greater governance and invest in research and evidence development before implementing healthcare policy.

Nevertheless the message may not be as gloomy in relation to cost savings as indicated by the authors. Firstly because the evidence for community rehabilitation as reviewed in a meta-analysis of 96 trials of 97,984 people by Beswick and colleagues is strong in terms of reduced nursing home admissions (odds ratio (OR) 0.87, 0.83–0.90), hospital admissions (OR 0.94, 0.91–0.97) and falls (OR 0.90, 0.86–0.95).¹ In addition, there was clear benefit from improved physical function. Secondly because even modest benefits in the reduction of admission to nursing homes (as cited in the paper) is both an outcome desirable to patients and because the cost saving to society is significant. In the current economic climate the NHS cannot operate in isolation to other publicly funded local authority partners where closer cooperation may benefit both in cost avoidance and must be considered unavoidable.

Robust evaluation, transparent accountability and good metrics have got to go hand in hand with any development however, so that we do not risk further follies.

And please, someone, invest in further research.

GRAHAM ELLIS

Consultant geriatrician and honorary
senior clinical lecturer
Monklands Hospital, NHS Lanarkshire

Reference

- 1 Beswick AD, Rees K, Dieppe P *et al*. Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 2008;371:725–35.

Endorsement of peer review

Editor – We read with interest the paper by Roberts *et al* (*Clin Med* June 2010 pp 223–7) describing their positive qualitative experience of peer review in respiratory medicine. We would like to further endorse the peer-review process based on our experiences in rheumatology.

In rheumatology, peer-review programmes are encouraged on a regional basis, using a nationally agreed proforma developed by the British Society for Rheumatology and the British Health Professionals in Rheumatology based on evidence-based clinical guidelines. Within the West Midlands region the cycle of multi-disciplinary peer review visits occur over a five-year period. Analysis of this programme demonstrated many qualitative benefits, including perceptions that peer review helped obtain more consultant posts, secure day case facilities, set strategies for the next five years, focus managerial requirements and foster a positive learning environment where strengths could be transferred between units. Quantitative analysis revealed many of the recommendations of the peer-review reports had been implemented. It was agreed that peer review was a worthwhile and constructive component of continuing professional development.¹ For some units there was a five-year interval between their peer review and our study which may explain why we were able to detect improvements in staffing and facilities; we agree with Roberts *et al* that their 12-month follow-up period may have been too short to capture changes in their respiratory services.

Roberts *et al* describe difficulties in recruiting patients into peer-review teams. In our most recent cycle of 11 peer-review visits we were able to recruit a lay person (patient or carer) onto each reviewing team but only seven visits went ahead with lay involvement, due to unexpected ill health of the lay person or their family (data unpublished).

Roberts *et al* raised the issue of the cost-effectiveness of peer review. We would suggest that our regional approach over a longer period minimises the organisation required, and that a one-day visit every five years may be a relatively low cost exercise for staff for a clinical governance activity which may yield significant potential benefits including multidisciplinary education, revalidation, and improving patient care.

HOLLY JOHN

Specialist registrar in rheumatology

Dudley Group of Hospitals NHS Foundation Trust

NICOLA ERB

Consultant rheumatologist

Dudley Group of Hospitals NHS Foundation Trust

IAN F ROWE

Consultant rheumatologist

Worcestershire Royal Hospital NHS Trust

Reference

- 1 Piper H, Hassell AB, Rowe IF, Delamere J, West Midlands Rheumatology Service and Training Committee. Experience of six years of a regional peer review scheme in rheumatology. *Rheum* 2006;45:1110–5.

Differential diagnosis of motor neurone disease

Editor – The review of motor neurone disease by Wood-Allum and Shaw (*Clin Med* June 2010 pp 252–8) was comprehensive and succinct. It did, however, miss the chance to highlight a very important differential diagnosis, Pompe's disease which is sometimes called glycogen storage disease type 2 or acid maltase deficiency. Recognition of this disorder is important because, although rare, it is now treatable with enzyme replacement therapy and the results are better the earlier treatment is initiated when muscle loss is minimal.

Pompe's is an autosomal recessive condition,¹ causing a deficiency of the lysosomal enzyme, acid maltase, (synonym, acid alpha-glucosidase) which degrades glycogen. This results in a build up of glycogen, particularly in skeletal muscle cells ending with cellular damage and destruction. When it occurs in juveniles or adults it presents with slowly progressive proximal muscular weakness and wasting, often involving the diaphragm and other respiratory muscles. Patients often languish for many years with an incorrect diagnosis such as benign progressive spinal muscular atrophy. The diagnosis should be entertained in all patients with slowly progressive proximal muscle wasting. Diagnosis is currently very easy, using enzyme assays on dried blood spots, leucocytes or cultured skin fibroblasts.¹

CLIVE TONKS

Lately honorary secretary, Association for

Glycogen Storage Disease (UK);

Emeritus consultant psychiatrist,

St Mary's Hospital, London

Reference

- 1 Van der Ploeg AT, Reuser AJJ. Lysosomal storage disease 2 Pompe's disease. *Lancet* 2008;372:1342–53.

Motor neurone disease: practical update ignores rehabilitative approaches – particularly assistive technology

Editor – The otherwise excellent review by Wood-Allum and Shaw (*Clin Med* June 2010, pp 252–8) made no mention of the role of the Motor Neurone Disease (MND) Association which supports patients, carers and professionals alike.¹ In some areas the MND Association has professional support workers who can work closely with the multidisciplinary team. This team may be supported by a consultant in rehabilitation medicine.

The authors recognised the importance of the multidisciplinary team but did not discuss the benefits such teams provide in ameliorating symptoms, particularly in the distressing later stages. Provision of assistive technology can have dramatic effects,

eg electrically operated beds, wheelchairs (which can be powered) and environmental control units (ECUs).

Electrically-controlled beds facilitate: control of dependent oedema, transferring in/out of bed and management of limb pain which may/not be related to spasticity. In the later stages of MND the control knob may need to be fixed close to the patient's hand, or be operated by an ECU.² Carers benefit when patients' can themselves control body posture in bed and thus do not need to call for assistance when patient's want to change position. Not all beds can be operated by ECUs and specialist advice is needed to know which can.

Powered wheelchairs are valuable in overcoming problematic immobility for users^{3–6} and assist their carers.^{3,7} They have been available for indoor/outdoor use in the UK since 1996.⁸ With sufficient technical support, these chairs can be controlled with integrated systems to enable communication, ECU and powered wheelchair to be controlled by a suitably sited control system.⁹ EPIOCs can also have recline functions to facilitate swallowing and breathing from the optimal seated position. Additional tilt functions prevent sliding forward in the chair and facilitate pain and pressure management.¹⁰ The mobile arm supports mentioned in the article can be fitted to either manual or powered wheelchairs.

ECUs have long been recognised as bringing benefits to those with progressive weakness which use about 20% of the ECUs provided in the UK. They facilitate independent operation of electrically operated devices, eg radios, heaters, lights, etc.

Assistive technology should be considered for those with progressive neurological weakness.

ANDREW FRANK

Centre for Research in Rehabilitation

School of Health Science and Social Care

Brunel University

References

- 1 MND Association. *What does the MND Association do?* Northampton: MND Association, 2010.
- 2 Paul SN, Frank AO, Hanspal RS, Groves R. Exploring environmental control unit use