We need time for training

Sir,

Tim Swanwick and Chris Bright (vol. 71(8), 2010, p. 424) are right to suggest that the solutions offered by the Temple Report to the problems of training under the European Working Time Directive (EWTD) are unaffordable. They are also undeliverable without major reconfiguration of the NHS, which is not going to happen. Why indeed should a European regulation on the hours worked by a small group determine the pattern of hospital care in the UK?

Apart from access to elective training and experience, junior doctors' rotas under EWTD are unworkable to the point of being dangerous. Layers of cover have been eroded leaving just one doctor covering large numbers of patients from several specialties (Commission for Healthcare Audit, 2009); and attempts to produce compliant rotas have increased the number of handovers, reducing continuity of patient care.

Temple criticizes a lack of supervision from consultants for juniors, but in the surgical specialties this is not usually because the consultant is unwilling to provide support. As described by the National Confidential Enquiry into Patient Outcome and Death (2009) the consultant has to perform out-of-hours emergency operations alone while the overworked single resident is too busy to come and be trained.

The only permanent, safe and workable solution is to remove acute specialities from the EWTD's grasp completely. Surgical trainee groups (Association of Surgeons in Training, 2009; British Orthopaedic Trainees Association, 2009) and the College agree that flexibility up to 65 hours (including time spent on call) would enable the best balance of safe services and adequate training opportunities with team working restored to allow continuity of care.

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Sir,

The findings and recommendations of Sir John Temple's review answered some tough questions on the impact of the 48-hour working week on training. Many of the suggested solutions are bold, with the need for a radical overhaul of the present system if we are to make every second count towards training and at the same time provide high quality health care.

The hardest hit specialties are the ones providing 24/7 acute care and the craft-based surgical specialties where competence and confidence (gained through more exposure) go hand-in-hand in delivering excellent patient care. Obstetrics and gynaecology fits both criteria.

It is reassuring that the coalition government has expressed a strong desire to implement the recommendations to maintain the proud legacy of this country's excellent medical workforce. A recent survey of trainees in obstetrics and gynaecology (Chatterjee, 2010) highlighted the poor implementation of EWTD in trusts with 90% of trainees having to cover daytime rota gaps at any one time. This has a huge impact on daytime training with 82% of ST2s and 28% of ST3s struggling to provide out-of-hours independent obstetric on-call cover.

There is robust evidence that health outcomes for patients can be improved by the presence of senior medical staff at unsocial hours. There is therefore an urgent need for expansion in obstetrics and gynaecology consultant numbers to deliver both high quality training and patient care, even in this time of financial austerity.

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Chatterjee J (2010) Summary of the EWTR RCOG Trainees Survey 2010. www.rcog.org.uk/our-profession/supporting-trainees/ewtr-trainees-survey/?utm_source=trog&utm_medium=email&utm_campaign=aug (accessed 20 August 2010)

Lithium enabling use of clozapine in a patient with pre-existing neutropenia

Sir,

Clozapine is the only medication licensed for treatment-resistant schizophrenia. Data from the Clozapine Patient Monitoring Service show that 0.4% of patients have a white cell count that is too low to allow initiation and 75% of such patients are of African or African-Caribbean origin (Atkin et al, 1996). Leukocytosis is a common finding in patients taking lithium and this property has been used to allow the initiation of clozapine.

A was a 26-year-old Caucasian male. He started to smoke cannabis on a regular basis at 18 years of age and was diagnosed with schizophrenia at the age of 19 years. Over the next 2 years only partial remission was achieved on both oral and depot antipsychotic medication at maximum licensed doses and he was hospitalized, often under the Mental Health Act, for long periods. He and his family received psychosocial interventions. Repeated full blood counts revealed neutropenia.

In view of his deteriorating mental state lithium was used to raise his white cell count – the neutrophil count increased from 2.1 to 2.8 x 10^9/litre in 2 weeks enabling him to start clozapine. The positive and negative symptoms of his illness improved dramatically. For the last 3 years he has been well on total daily doses of clozapine 400 mg and lithium carbonate 800 mg and has obtained employment. He developed hypothyroidism after a year and his neutrophil count has always been in the normal range.

This demonstrates that, while not licensed, lithium could be used to initiate clozapine in patients with pre-existing neutropenia.

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Atkin K, Kendall F, Gould D, Freeman H, Liberman J, O'Sullivan D (1996) Neutropenia and agranuloytosis in patients receiving clozapine in the UK and Ireland. *Br J Psychiatry* **169**: 483–8