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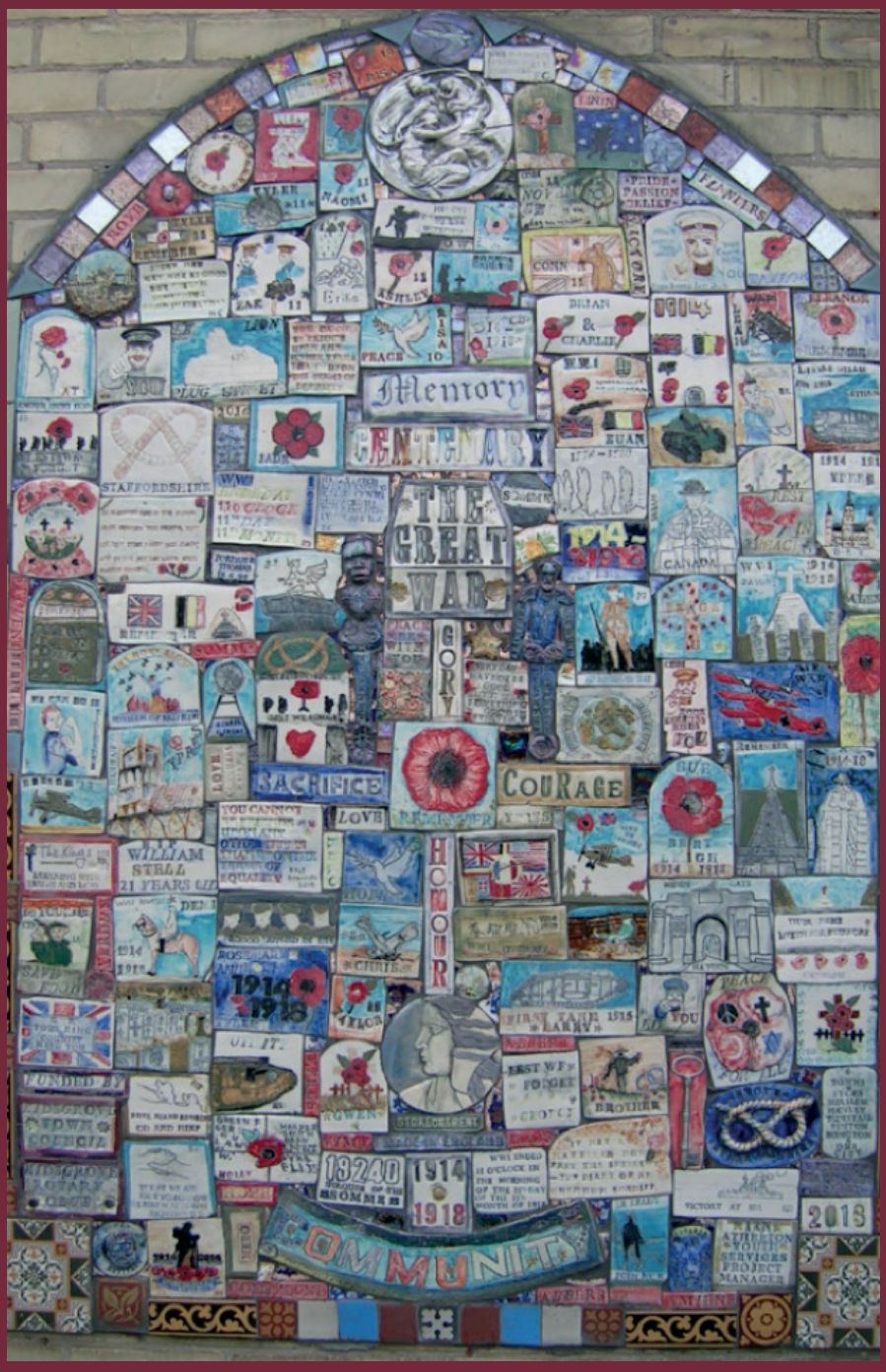

Midlands Medicine is the journal of the North Staffordshire Medical Institute, whose purpose is to promote postgraduate medical education and research. The journal was first published in 1969 as the North Staffordshire Medical Institute Journal.

COVER IMAGE
Kidsgrove Library memorial plaque. Picture credit: Helen Alcock.

FURTHER CREDITS

Pictures of the award winners were taken by Mark Smith.

Apologies to Jonathan Charles for omitting him in the byline of the vascular quiz in the last issue (May 2017).

MIDLANDS MEDICINE

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EDITOR'S NOTES

This November we will once again be observing Remembrance Day. We are in that particularly poignant period when centenaries of the First world War keep coming with diary regularity. This year so far, amongst others, have passed the centenaries of the Battle of Otranto Straits, the Third Battle of Ypres, the Battle of Paschendale and the First Battle of Ramadi. A look at any of these would quickly bring strange feelings about the wars that raged around Europe 100 years ago. More recently, the film Dunkirk, featured several perspectives in an interwoven narrative of events within the memory of those in their later years. Each one of us will have our own view of the proper and appropriate way for a any healthcare professional or doctor, charged with preserving life and health, and alleviating suffering, should behave in a theatre of war. Many of us will never have been put to the test. Even fewer of us would have come up with the approach taken by Desmond Doss. In his article, Medical Student Sam Olyott explores the example: exemplar of courage, fortitude, rectitude and integrity provided by US combat medic Desmond Doss. Though perhaps many of you will not be familiar with this passage of history, there is much for us to take from it and Sam helps us relate his story to our ethics in today's NHS.

From the past and the present, we move to the future as one of our own Editorial Board members gives a personal take on proposed changes to nurse training. Tracy Hall is concerned that at a time when recruitment of nurses is difficult, made more so this year by the withdrawal of student nurse bursaries, this particular attempt to modernise nursing might not be quite the right thing for these austere times. The developments are intriguing and ambitious, but are they what is needed just now? This is a very interesting question with implications far beyond the nursing profession. If you have any interest in education or training of any healthcare profession, you find relevance here.

Relevant to all of us, potentially, and more so as we age, is some form of end-of-life planning. Death is no longer followed by an open house with an open coffin and moved over latter decades of the 20th Century into the territory of taboo. But if we don't talk about it we can't know what people want or tell them what we're prepared to do for them, or not do for them; if we can't talk openly we fall into a fog of silence: care could be compromised, or be inappropriately bad. We need to talk about resuscitation and DNACPR orders more openly: Paul Laszlo shares some of his thoughts on the matter.

Another difficult topic for some people might be the menstrual cycle. But if you work in O&G, assessing menstrual disorders is a regular requirement (or possibly irregular) and PreMentricS is a 'phone app that does just that. Why you need a computer algorithm to take a decent menstrual history might elude you unless you realise that "Almost 200 different symptoms are experienced by women suffering from premenstrual syndrome." Next, Divya Chari and her team serve us neuropathology on a plate, or at least explain how that might be possible. They give an account of keeping human neural tissue alive *ex vivo* sufficiently long to allow an injury-then-healing model to be used to assess potential damage limiting therapies. These very different projects are two of those supported by grant funding from the NSMI and these reports give you a chance to see what can be done with the institute's help.

Outside the institute, Keele University societies are alive and well. There are a number of societies in the medical school alone. Georgios Solomou has had an exciting time grappling with learning basic surgical skills in a very open setting. Plenty of innovation, leading and learning clearly went on when Keele Surgical Society hosted a suturing course, turned competition, to find the student a cut above the rest.

This year's Awards ceremony was held a little earlier, in September, and so we have captured the event in this October issue of *Midlands Medicine*. Much money has been handed out to support a wider variety of research projects than ever before and to reward medical students for good performances and researchers who communicate their achievements well to a wide audience. Continuing the theme, we were delighted to have Jim Al-Khalili, holder of a Chair in the Public Engagement in Science at the University of Surrey deliver this year's Wade lecture entitled "Does Life need Quantum Mechanics?"

If second hand quantum mechanics is perhaps a little too challenging for you, then the usual round up of end pieces might be just your cup of tea instead.

Happy reading!

MAKING MODERN NURSES

Tracy Hall, Medicines Management Nurse Consultant

By the time you read this the NMC's Consultation process into the future prerequisites of a newly qualified nurse will be over. The results of the consultation process which ends 12th September 2017 will be incorporated into the document launch for early next year with early adopters implementing in September 2018. This summer the NMC launched the opportunity to directly take part in a web-based consultation process[1,2], this was in conjunction with various road-shows which others such as the RCN are undertaking. The proposals, whilst some may consider them to be patronisingly insulting to the profession as a whole (the proposed standards of proficiency state that a registered nurse must be able to offer basic nursing care such as assistance with nutrition, hydration and skin care), underpin the principles set out within The Code for nurses and midwives (NMC 2015).[3] The Code, when launched, did cause some consternation for registered nurses who felt aggrieved that our professional body was telling us explicitly that as registered nurses we needed to provide basic nursing care. Some may have felt it was necessary as we had lost our way, especially given some of the negative press the profession has received recently. Nursing has changed drastically over the years, as we have adapted in order to meet the varied and changing needs of all who we encounter, yet the ability to be able to provide evidence-based care in a holistic manner is the essence of what we do. It wasn't that long along ago that nurses weren't allowed to perform certain tasks that were traditionally within the medical domain. I can remember in the early 1990s being taught to take blood and to insert cannulas. Whilst reducing the workload of junior doctors it helped the patients in our care receive their IV medication in a timely manner and not have to wait until the junior doctor was free. (On the negative side, we had a number of junior medics who had become deskilled.)

As nurses advanced and took on roles previously in the medics' domain, not only did we deskill medics to a degree, but we in turn had to relinquish certain aspects of the registered nurses' role to our health care support worker colleagues. Tasks previously performed by the Staff Nurse such as bed-baths whereby there was opportunity for a comprehensive holistic assessment encompassing all aspects of care such as skin integrity, assessment of efficacy of analgesia, mental health, nutrition and hydration were no longer a priority for the qualified nurse as a result of competing demands, giving a dilemma over art versus science of nursing care.

It was of interest when reading the proposed standards of proficiency for newly qualified nurses[1] noting how much nursing has moved on and further integrated into a medical model of care provision. The proposals are that there is a standardisation of the core competency of all newly qualified nurses; this is an absolute must and I totally agree that it should not be dependent upon where you train as to what core skills you achieve such as the ability to give IV (intravenous) medication safely and competently. Nurse training has got to be fit for purpose and equip our future nurses with the core requisites of a modern nurse.

Is it a step too far, though, for newly qualified nurses to be able to prescribe on qualifying or shortly after albeit from a restricted formulary?[2] I absolutely agree that within the course there needs to be emphasis upon anatomy and physiology and I also agree with the proposal of integrating the Royal Pharmaceutical Societies Standards[4] into the pre-registration courses in order to enhance pharmacology knowledge. The NMC Code[3] in Section 18 explicitly states the requirements of a Registered Nurse in relation to administration of medication; yet pharmacology knowledge is an area that is not often given as much in-depth review as it should be. For some nurses at the mention of pharmacokinetics or pharmacodynamics can result in a glazed expression. Latest figures from the NMC[5,6] reveal that between January and March 2017, 706 nurses were reported to the regulator; of these 126 were related to medicines management and prescribing though the biggest cause for referrals was related to patient care of which there were 136 referrals. New cases to the NMC are increasing: during 2016-2017 there were 5,476 nurses referred for various reasons. Currently only 76% of fitness to practise cases were completed within 15 months. Of these there was a marked increase in the number of nurses struck off with 344 removed from the register during 2016-17.

The consultation document[1,2] refers to the following things a newly qualified nurse should be able to do:

"4.11 Demonstrate the principles of safe and effective optimisation and administration of medicines in accordance with local and national policies. Demonstrate proficiency and accuracy when calculating dosages of prescribed medicines.

4.12 Demonstrate knowledge of pharmacology, to inform safe prescribing from an agreed formulary, recognising the effects of medication, allergies, drug sensitivities, side effects, contraindications, incompatibilities and the impact of polypharmacy.

4.13 Demonstrate knowledge of methods for generating prescriptions and the role of generic, unlicensed and off-label prescribing. Understand the potential risks associated with these methods".

Another aspect listed with the expected competences refers to the registrant being able to: "*undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product".*

Transcription is currently a hot topic nationally especially within primary care however the current NMC Standards for Medicines Management (revised 20167) clearly states that transcription should be performed in exceptional circumstances only.

Whilst there are competences listed traditionally associated with that of a registered nurse, there is also a proposal that a newly qualified nurse should be competent from a physical assessment2, including to the extent that they should be able to interpret blood test and blood gas results, perform chest auscultation and interpret findings, undertake a full cardiovascular risk assessment, interpret cardiac monitors and manage and interpret common ECG recordings. This is set against a backdrop of the newly qualified nurse displaying political awareness, of having the basic skills required for business case planning as well as displaying the attributes of leadership and pastorally caring for people within their care, both patients or colleagues.

The NMC Consultation into withdrawing the Standards for Medicines Management and amending the Standards of Proficiency for Nurse Prescribers[2] brings other thoughts into the equation. The NMC propose removing the requirement for a medic to be the mentor for a nurse to undertake the Independent Prescribing Qualification, referred to as the V300. The proposal is for a suitably qualified experienced prescriber. Whilst this would solve the problem of sourcing adequate numbers of doctors to support nurses to undertake this study I wonder how much consultation has taken place with them about losing this collaborative role which also gives them a degree of oversight. I remember the opposition I faced as someone who studied one of the early courses whilst working within community nursing; interestingly one of the concerns was the amount of junior doctors' roles we as nurses were taking on. How things have changed in the past 14 years!

If we raise scope and standards and expectations of nurses even at the very outset of their practice, it seems a near certainty that in the future we will see an increase in the numbers of registered nurses referred to the NMC due to concerns over their ability to provide safe effective patient care, particularly given the increased medicalisation of practice and adoption of tasks that previously followed a period of consolidation of practice. When you take into account the pay scale for a newly qualified nurse and the role expected of them, is it any wonder that universities have seen a reduction in applicants and the NMC has seen a reduction in registered nurses wishing to be registered? Worryingly the NMC reported in July 2017[5] that for the first time in recent history the numbers leaving nursing are now outstripping the numbers joining the register, with this trend most pronounced for UK nurses and midwives, who make up around 85 per cent of the register. Between 2016 and 2017, 45 per cent more UK registrants left the register than joined it for the first time. Data also suggest that more nurses and midwives are leaving the register before retirement age with a noticeable increase in those under 40 years leaving nursing.

The NMC are also proposing the removal of the current standards underpinning medicines and prescribing for nurses within the consultation process.[2] This potentially could be a contributing factor in inequity in future standards as Trusts and organisations who employ nurses base their medicines policies on these documents. If the GMC8 as a regulatory body can also provide prescribing guidance to the clinicians they represent, then surely the NMC can follow suit?

We all want a nursing workforce that is fit for purpose and ready to encompass the challenges of modern day healthcare provision. However, fundamentally we need to get it right first and foremost for colleagues currently practising as a registered nurse. We can't afford to sustain the continued haemorrhage of experienced staff leaving the NHS. According to the RCN Bulletin[9], not only are we seeing a reduction in applicants to become a student nurse following the change in the bursary arrangements but we currently nationally have one in nine established posts vacant. The RCN have undertaken lobbying with various 'Scrap the Cap' events with a call for potential strike action by nursing staff. We are facing a crisis, a tip of the iceberg, as we face the reality that nurses are leaving the profession in droves; we have an ageing workforce balanced and a reduction in new applicants. Whilst the NMC are to be commended on reviewing the proposals for the nurse of the future, are these the right proposals and, if they are, can we afford to wait until 2030 for this to come into effect? As potential future users of the NHS we might all want answers to these questions.

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WE NEED TO TALK ABOUT RESUSCITATION

Paul Laszlo, Consultant Physician

"We urgently need a national conversation about death and dying to dispel myths and to inform the public about the reality of CPR and how it affects end of life care." Tracy Masters[1]

Some conversations are not so easily had, withdrawal of life-sustaining treatment* and considering organ donation among them. But the setting probably raises expectations that such discussions might take place. Sometimes this will be true of DNACPR (Do not attempt cardio-pulmonary resuscitation) decisions: context will dictate that this is a naturally sensible talk to have. Often, however, there's not easy time to raise the difficult topic. If that's the not the case, how do you raise the subject without being awkward and uncomfortable yourself and without raising surprise, anxiety and upset in the patient (or their relatives - and that's another story: considered below)? One could be open: "What would you like us to do for you if your heart stops?", technical and direct: "If your heart stops beating, do you wish us to make an attempt at cardio-pulmonary resuscitation?", or direct in the vernacular: "If your heart stops are you expecting us to jump up and down on your chest and give you electric shocks?". The trouble with that last phrasing is that, however subtly, it implies the negative and looks like the doctor is expecting a negative response. So, not only is this a tricky subject to raise, but the actual way, tone of voice, non-verbal cueing and words used also matter a great deal.

In a more open society, transparent you might say, we need to talk about resuscitation. We should talk with patients about their resuscitation status, or DNACPR wishes. More notably, relatives often now want, and/or expect, to be included in conversations about DNACPR orders, possibly more vehemently than the patients who are the subject of them, possibly because, at the end of the day, they are the ones left behind with their memories after the patient has been allowed to pass peacefully on.

Recently I reviewed a patient with a long term condition. She is a regular and very definitely multi-morbid. She lost her husband a couple of years ago and life has not meant quite so much to her since then. We regularly discuss her ongoing treatment and contingencies such as what would she like us to do if she collapsed. (Even as I write this, I get the point that in having apparently candid conversations about resuscitation wishes I am using a euphemism by talking about collapsing instead of talking about dying or her heart or breathing stopping.) After the first time, when we have a thorough and open discussion on the matter of resuscitation choices, we subsequently usually just brush lightly against the subject. That is until a patient has a change of mind and wants to make an adjustment, in which case we once again go into a more detailed discussion; usually the process involves merely confirming the established position as documented in the last clinic letter.

On this occasion we confirmed her decision that she wishes not to be resuscitated in the event of cardiac or respiratory arrest. (This is by far the less common view taken, even by the frail elderly comorbid patients in whom the will to live often will not die. A straw poll would suggests about 4% make the DNACPR election.) Then we went into things a little more, went over them for the purposes of her refreshing my memory, making sure I had the right version of events stored away in my mind's archive: What she remembered of her decision-making process was that she formed the view that her life was becoming more of an effort at existence than a joy or a necessity to her. She has a monotheistic faith and an adoring and respectful family, so she is not keen to leave them or do anything to disrespect her maker but she also very clearly dreads the idea of being any more ill than she already is, dying and then being brought back to life at a lower standard of functioning only to go through things all over again at a later date. In some ways she longs for the peace death might bring her, and re-joining her husband. For her, this is balanced against the grief she knows her death will cause her family, for which she already feels some anticipatory guilt. So, she has decided that she will comply with treatment efforts and so keep herself as well as she can be, and do nothing to hasten her demise, but that resuscitation is clearly not something she wants to go through or come through. ("Just draw the curtains and leave me be.")

So, how to give effect to her wishes? Firstly she spoke with her children and explained things to them. Once they had digested, debated and ultimately accepted her position she arranged to discuss things with her GP to arrange a Community DNACPR Order. She also arranged to see me to discuss her decision, rather, more accurately, to inform me of her decision and make sure the paperwork was in place to cover the hospital end of things. After full discussion, listening to her thoughts behind her decision, understanding her perspective, I was helped to accept her decision too. All was recorded and the forms duly filled in and filed appropriately.

This is perhaps both a good but unusual example of an activated patient who must take a great deal of credit for her active efforts to sort things out to be the way she wants. But perhaps a little credit might also be directed to the fact that the topic of resuscitation status is touched upon as a matter of routine in the clinic thereby giving permission and partly normalising such conversations.

There is a danger that DNACPR decisions are segregated off and seen as something specific and as an isolated aspect of patient management. They are vulnerable to this because they have special bits of paper to document them, which are made particularly visible, and so are easily counted. (Recent guidance from the DoH regarding the reviews of hospital deaths specifically asks for note to be taken of the presence or absence of a DNACPR order.) Future care discussions with patients and/or relatives ought to be holistic: attitudes and expectations, hopes and fears, likes and dislikes can all be considered. When talking disease trajectories, or even just life trajectories, with patients in an open and broad way, end-of-life planning naturally encompasses questions of hospital admission (or not) escalation and ceilings of care and wishes around attempts at resuscitation. These conversations are better done well in advance of acute illnesses in clinic or the community, should be revisited and revised as appropriate and both clearly documented and effectively communicated to all who need to know (as often happens with 'Community DNACPR Orders'. One other important outcome of these conversations and how to document them is when a patient does wish an attempt at CPR but places their own limits thereafter stating that they would not wish to survive in a highly dependent state (often expressed in more direct terms involving vegetable).

IMAGE COMPETITION

One of the key challenges to producing a good edition of Midlands Medicine is to source the cover image and the other is to source the interesting images. We would like to give you the opportunity to help us out with that by submitting your beautiful, spectacular and interesting images for publication in the journal. In addition to the kudos of publication, monetary prizes of suitable worth will be made if your submissions are published.