61st RCPE St Andrew's Day Symposium

Day 2: 26 November 2021

Minimum unit pricing – is it working? - Professor Ewan Forrest

Q. If the alcohol-related attendances that were shown not to change included alcohol withdrawal attendances, were they expected to go up as people with dependence struggled between drinking when they had money and then suffering withdrawal when they ran out?

A. Anecdotally there were cases of some patients presenting with AWS as they couldn't afford to maintain their excessive alcohol intake, however overall the figures for AWS admission were fairly static

Q. Do you think there has been a significant change in consumption related to the pandemic eg more people drinking more at home vs in pubs? Is there any data available yet to support this?

A. Definite changes in alcohol drinking with COID: much more home (off trade) drinking: polarisation of dinking behaviour in that some are drinking less, but evidence that about 20% are drinking more (and these may be more vulnerable individuals)

Q. is there any relationship between reduction of alcohol deaths and the increase in drug deaths and polysubstance abuse?

A. No association. The increase in drug deaths has been occurring before the introduction of MUP, especially with regards to street Valium (etizolam) related deaths

Q. Was there an interaction between deaths from COVID among those with alcohol related liver disease and deaths from alcohol related liver disease itself - could a rise in the former among more deprived populations have reduced the latter in the same populations?

A. Patients with chronic liver disease were at greater risk from COVID, however the fall in deaths in the most deprived quintile in Glasgow occurred after the introduction of MUP but before the onset of COVID.

Q. Could the improvement be due to confounders such as better rehab services?

A. Certainly this could be a factor, and it is important to regard MUP as just one of a series of measures introduced to reduce alcohol harm. This included improved rehab. However the improved investment in rehab occurred years before MUP but the greatest impact seen on harm was after MUP specifically

Q. Price increase will increase tax collected for HMG. Is this a conflict of interest for those who make the decisions to increase MUP?

A. Actually the main beneficiaries of MUP are the drinks companies rather than HMG. MUP is not a tax.

Q. What is considered an alcohol related death ie is trauma included in this? What lag effect would you expect to see following a societal increase in alcohol intake? Will we see a surge in 5-10 years and if so what else can we do as a profession?

A. Alcohol-specific deaths are defined in the following document: The impact of using the new definition of alcohol-specific deaths - Office for National Statistics (ons.gov.uk)

Q. Has there been evidence of increase drinking among teenagers?

A. No specific data in teenagers, but there may have been an increase in young adults (<45 years) drinking during the pandemic

Abnormal liver function tests (LFTs) - Dr Andrew Fraser,

Q. what level of ALT (example two times upper limit?) should we consider further investigations such as noninvasive liver screen?

A. This is context specific. If we are talking about patients who are asymptomatic then we use an ALT level of 30 to prompt further investigation through iLFTs. If further investigation is limited to 2 x Upper Limit of reference range then a significant number of people with underlying liver disease with the potential for early intervention will be missed. It is important that to appreciate that a lot of the liver screen tests only need to be done once and not repeated to give reassurance to patient and clinician. Often patients are getting repeated LFTs that are not adding anything.

Q. Does vitamin K really benefit patients with abnormal PT/INR who is not bleeding?

A. Short answer is I think not. This is only a measure of the lack of the procoagulant vitamin K dependent clotting factors and does not reflect the overall coagulation status of the patient as there will also be deficiency of the anticoagulant clotting cascade

Q. If incidental mild abnormal LFT's found on patient that could be discharged from front door, should follow up be passed on to the GP to ensure fully investigated?

A. Yes but this is a situation that the GP may want to repeat prior to investigation as a large number of patients who have incidental abnormal LFTs at the front door have normal LFTs after a few days. We have evidence that doing the fibrosis markers on admission bloods of patients with alcohol related disease who are admitted is significantly poorer than doing them on their discharge.

Q. What's other common causes of isolated elevation if GGT. Sometimes I feel we have bias towards people with GGT despite them denying it.

A. Fatty liver disease is a common cause but so is non-hepatic illness.

Q. For pt on Methotrexate, We use double ALT Value(110) to withhold medication and once normalised (55 level) we restart in a smaller dose. Should we reduce the threshold ?

A. I am not sure of the evidence behind those figure and whether it is an absolute or relative rise. Presumably these figures were chosen for a reason. There was another question about something being withheld at 5 times Upper Limit but again I think this is arbitrary. There are different methotrexate toxicities, of inflammation and fibrosis. The ALT rise would mainly be looking at the

inflammation whereas I think what you are particularly interested in is the fibrosis. It may be more relevant to look at factors such as the FIB-4 score.

Q. Will iLFT be implemented in Aberdeen soon?

A. I know that Jim Allison in Biochem is looking into this.

Q. If a patient has raised FIB4 score, what do you think about having GPs a direct access to Fibroscan, and only refer to secondary care if Fibrosis F3 or higher?

A. That has been used in Community studies and needs to be financed. The alternative would be to implement the Camden and Islington method of having Enhanced Liver Fibrosis (ELF) score as an intermediary and only referring those with elevated ELF.

Caring for doctors as well as their patients - Dr Caroline Elton

Q. How do we decide, and who decides it, that what is the right balance between being a bit too resilient, and being too reliant on and demanding support too many times for too little things? Also, do you think this issue may be in the minds of many doctors, particularly juniors?

A. To answer the second part first - yes - I do think this is in the minds of many drs, particularly jnrs.

As for the answer - well it's incredibly difficult, but I suppose one important issue to consider is that of self-awareness. Part of maintaining one's wellbeing can be knowing when to say no, and when to hold a tendency to perfectionism in check. So being too resilient can be a problem if actually one is soldiering on at the expense of one's personal wellbeing. Learning to monitor that, and take action when necessary, is crucial.

Q. Is the sense of moral injury partly a consequence of doctors being poorly trained to deal with value conflicts, at least when compared with the training of social workers?

A. I think that's a fair observation. And perhaps it's not just social workers - but the military as well, could provide some lessons. The problem is that wider society doesn't always accept the reality on the frontline in which doctors can be forced to make impossibly difficult, potentially morally compromising choices. But I think your observation is valid.

Q. You talk of the benefits of the old "firm" compared to the shift system. You also mention, negatively, "tribalism". I equate the "firm" to tribalism. How do you see "firms" as they used to be and are we at risk of forgetting the sexism and racism that it sometimes led to?

A. I thought I spoke about the fact that all sorts of prejudicial stuff could lurk within old style firms (sexism, racism, homophobia - to name a few). So yes - firms aren't a magic solution. But at their best - they provided a sense of belonging within a small team. Tribalism, to me, speaks of 'isms' where you are either in or out. But the firm, when it worked well, didn't judge on these predetermined categories, but gave you a sense of belonging to a small unit that would train you and support you.

Q. What safeguards are there for doctors from difficult, rude and constantly complaining patients? I have seen medical and nursing colleagues having to put up with significant verbal abuse from patient with no real option but to endure it due to lack of safeguards for us.

A. That's so difficult - and definitely no easy answers. But if a team member has been verbally abused - then the most senior member on duty at that time has a responsibility to go and express their displeasure to the patient (within the bounds of respecting patients, accounting for mental illness, etc) - and, also to provide support to the verbally abused staff member. Definitely no easy answers. But strong, visible, supportive leadership can make a difference in this incredibly tricky situation.

Acute kidney injury and the ageing kidney - Dr Fergus Caskey

Q. Given the lack of evidence of benefit, should we therefore abandon AKI eAlerts?

A. No, I would not say that. I think more work needs to be done to optimise the way we use them/ respond to them

Q. Do you give sick day rules to patients?

A. No, not in all cases. Only where I think the patient is particularly at risk of AKI that may be harmful. I do worry about the unintended consequences of sick day rules on adherence with medication proven to reduce cardiovascular events with much smaller NNTs.

Q. While treating the underlying driver, if you chose NOT to treat AKI, would the mortality remain same?

A. The way to treat AKI is to treat the underlying driver, whether than is sepsis, volume depletion, obstruction, or glomerulonephritis? At the moment there no unbiased (RCT-level) evidence that treating these in a more concerted way that we did before AKI e-alerts reduced mortality at a population level.

Q. If RAASi causing RTA 4 in patient with CKD, is there still benefit of continuing these medication in this population or not?

A. Here you are getting beyond the 'evidence'. I suspect such a person would have failed screening for the trials. It would depend on whether you could manage the hyperkalaemia sufficiently and then whether the indication for the RAASi was strong enough. It is a bit of a stretch, but looking out to the dual blockade of the RAAS evidence, it did not require very many episodes of AKI/ hyperkalaemia requiring acute dialysis to cancel out any benefit of dual blockade.

Complex multimorbidity -Professor Frances Mair

Q. Do you think that palliative and supportive care integrated working with other specialties would be useful? There are no age ranges

A. That sounds like a very interesting idea, and definitely one worth exploring. It might could be part of a potential project for one of our future Multimorbidity PhD rounds

(https://www.gla.ac.uk/colleges/mvls/graduateschool/multimorbidity/). Would be happy to discuss this further.

The acute team – use of treatment escalation plans to reduce patient harm - Professor Robin Taylor

Q. Given current restrictions on hospital visiting, especially in acute areas, what are your thoughts on having conversations with families about TEPS over the phone?

A. If there is no possibility of F2F then it is an approach that we have to accept. But there is a style and content that are important. Delegating decision-making to next of kin can be problematic. They may feel "on the spot" or that a decision is too big for them, especially if it means withholding treatment. Outlining the proposed goals of treatment and then asking "What are your thoughts?" is open ended and I find it helpful.

Q. Should TEP be placed for short stay medical patients who are stable?

A. It depends on the patient's vulnerability. to deterioration. The facct that they are short stay should not be the deciding factor. I accept that you don't want unnecessary work, but if a short stay becomes a long stay and this was not entirely a surprise, then retrospectively it is probably the case that a TEP should have been in place.

Q. Do TEP discussions need to be altered in covid pts? ie someone who would be for short ICU stay post op vs not for ventilation for ICU

A. I am not the best person to address this question. My understanding is that the indications for escalation to ICU are probably the same as for any patient now that the fear of having only a limited number of ICU beds has subsided i.e. the reasons for triage as they were in April 2020, are now modified. Remember to talk about the **consequences** of ICU admission including loss of cognitive function long term. I recently had a lady who, when this possible adverse outcome was mentioned, declined to go to ICU. "I'll take my chances", she said

Q. Do you think TEPs/advance care planning should be done within the community itself?

A. Anticipatory Care Planning in the community is a great help in preparing the patient for the conversation if they end up in hospital. . The TEP is really directed at how to manage the patient if they deteriorate in hospital and it goes into specific details. The ACP is more holistic and general and in any event all the issues need t be discussed again given that circumstances have changed (otherwise the patient would not have come to hospital)

Q. How do you deal with conflict in TEP where clinician recommendation differs from next of kin views (where pt has no capacity)

A. It is not easy. The principle to keep in mind is that you are the patient's advocate when it comes to avoiding what is likely to be futile or likely to be harmful. Resort to offering a second opinion if necessary. Make sure that you and your colleagues have an understanding that you will be willing to offer a second opinion as much as being willing to arrange for it to happen.