Preliminary observation suggests that non-
fatal overdosing is linearly related to polydrug
use; among the 298 subjects who had injected
only one drug 57 (19%) had taken an overdose,
compared with 29 (40%) of the 72 who reported
injecting six or more drugs. Among the 116
using multiple drugs excluding heroin, however,
only 10% reported overdosing, compared with
22% of the 241 who had injected heroin only and
32% of the 661 who had injected heroin plus
other drugs (table 1).

1 It is important to note that the drugs shown in
table 1 do not relate specifically to overdoses;
they relate to general patterns of drug use in the
six months before interview. Use of temazepam,
cocaine, and ecstasy was associated with an
increased risk of overdose. In contrast, use of
methadone was not associated with overdosing,
although we are currently conducting a more
detailed study of overdosing among drug users
who have been prescribed methadone as a part of

Private practice

Offering preferential NHS treatment to
doctors is embarrassing

Enron—I entirely agree with David Currie's
personal view about private health insurance. I
would not allow myself or my family to be treated
anywhere other than in NHS hospitals, because
for all its difficulties the NHS provides a full
range of health care in an accountable manner.1
But I have had private insurance since I was a
senior house officer. Why? Because I am embar-
assed by the preferential treatment and queue
jumping that my colleagues (and I myself) offer
to doctors and their families. By taking myself
and my family into the private sector I am not
pushing someone else down the list; I am not
making staff equally uncomfortable about treating
us differently or treating us the same.

What I would not contemplate is treatment in a
private hospital—without access to full medical
records, dedicated nursing staff led by people
interested in quality and progress, highly selected
junior doctors with structured supervision of their
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to consult if all is not simple and straightforward.

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Table 1—Self-reported drug use and non-fatal overdose among 1018 drug injectors interviewed in Glasgow, 1993-4

<table>
<thead>
<tr>
<th>Drug used or injected in six months before interview</th>
<th>No (%) using drug</th>
<th>No (%) reporting overdose</th>
<th>Relative risk (95% confidence interval) compared with rest of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injected heroin only</td>
<td>241 (24)</td>
<td>52 (22)</td>
<td>0.7 (0.5 to 0.9)</td>
</tr>
<tr>
<td>Injected heroin and other drugs</td>
<td>661 (65)</td>
<td>213 (32)</td>
<td>2.2 (1.6 to 3.0)</td>
</tr>
<tr>
<td>Injected drugs excluding heroin</td>
<td>116 (11)</td>
<td>11 (9)</td>
<td>0.3 (0.1 to 0.5)</td>
</tr>
<tr>
<td>Methadone</td>
<td>453 (44)</td>
<td>132 (29)</td>
<td>1.2 (0.9 to 1.6)*</td>
</tr>
<tr>
<td>Baclofen</td>
<td>458 (45)</td>
<td>109 (24)</td>
<td>0.9 (0.7 to 1.1)*</td>
</tr>
<tr>
<td>Temazepam</td>
<td>793 (78)</td>
<td>244 (31)</td>
<td>2.7 (1.8 to 4.0)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>179 (18)</td>
<td>57 (37)</td>
<td>1.8 (1.3 to 2.5)*</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>268 (25)</td>
<td>99 (38)</td>
<td>2.0 (1.5 to 2.8)</td>
</tr>
</tbody>
</table>

*Not significant.

Readers may laugh at this description of an NHS
hospital: I would have to agree that it is not quite
like that, but it is our aim.

Do I engage in private practice? Yes, occasion-
ally, if people are insured and are also eligible
for NHS treatment so that I never have to give
a lesser service. And only in the private ward of
an NHS hospital. What do I think patients get out
of "going private"? Self esteem, their own
bathroom, and quiet nights. What do they lose?
The context in which to judge the severity of
their condition and progress, camaraderie with
staff and patients engaged in making the NHS
work, and the privilege of training the new
generation of professionals.

People should not give up on an organisation
that is imperfect only from the inside—whether
it be as a BMA member, an NHS consultant,
a recognised BUPA specialist, or a patient—
can they influence it.

MARY G BARRINGTON
Consultant physician in medicine for the elderly
Airedale General Hospital,
Keighley BD20 6TD

1 Currie D. BUPA subscription? That will do nicely. BMJ 1996;313:431. (17 August.)

Some standards of staffing and equipment
should apply in NHS and private sector

EDITOR,—I endorse everything that David
Currie writes in his personal view about private
practice.1 Some 40 years ago I joined a long
established practice in north London. "We try
to send patients in privately," explained one
of the partners; "we find too many come out feet
first." Nothing like happened over the subse-
quent years changed my view. In fact, so
convinced am I that the best of health care is
provided by the NHS that I have waited,
sometimes in pain and unable to walk, for the
tree joint replacement operations I have had
over the past three years. Fortunately, any
complications I have had have been minor, but
during my most recent admission two patients
had cerebrovascular accidents one Saturday
morning. Other patients and I may have felt a bit
neglected, and I do not know the eventual
outcome, but I do know that expert care was
there immediately, on the spot.

It is not that I have any principled objection
to private practice; people should be allowed
to spend their money as they like, and if access
to a secretary and a good wine list are important
they may choose the private sector. But they must
do so in the full knowledge of what they are buying.
I want that fashionable concept of our age, a level
field playing. Incompetent doctors who have
been dismissed from the NHS should not be
allowed to continue in private practice; the same
standards of staffing and equipment should
apply in both sectors; and the endless criticisms
of the NHS that appear in the press—often, in
my experience, baseless—should be matched by
similar scrutiny of private hospitals.

In a matter of some interest to the profession
that so many doctors have been prepared to treat
patients for money in circumstances that they
knew were not satisfactory. Perhaps I should add
that neither I (a general practitioner) nor my
husband (a surgeon) took private patients for
exactly the reasons that Currie states.

ANNIE SAVAGE
Retired general practitioner
7 Abenale Road,
London NW3 5RA

1 Currie D. BUPA subscription? That will do nicely. BMJ 1996;313:431. (17 August.)

Author is lucky that his waiting list can be
managed quickly

EDITOR,—It is lucky for David Currie that he
works in a unit and in an area of Britain where
the waiting lists can be managed quickly and
personally, making private insurance less
attractive.3 It is also fortunate that he works in
a field in which the need for private care is less
than in other fields and the need for first class
back up in the NHS is essential and recog-
nised as such by the NHS administration.

There are many reasons for the size and nature
of any surgical specialist waiting list, and "fiddling
the system," as Currie suggests, is not the main
one.1 In my own specialty of plastic surgery most
cosmetic, non-malignant, and non-traumatic work
is not covered by insurance, and, because of the
continual heavy input and referrals, waiting time
and waiting lists are difficult to control. Some
patients elect to have private treatment and pay
for it themselves, mainly for convenience and speed;
in some cases they indicate that they are happy
to have the freedom of choice and, by removing
themselves from the NHS, allow others to take
their place in the queue.

JOHN C MCGREGOR
Consultant plastic surgeon
St John's Hospital,
Livingston,
West Lothian EH54 6FP

1 Currie D. BUPA subscription? That will do nicely. BMJ 1996;313:431. (17 August.)
2 McGregor JC. Can a workload coding system be used to assess and monitor a plastic surgery waiting list? J R Coll Oral Surg 1994;41:50-3.

Many reasons exist for choosing private
practice treatment

EDITOR,—Having read David Currie's personal
view about private medicine, I am not sure
whether to pity him or be jealous.1 His article
must surely have been written tongue in cheek.

Does he really not know the use of having a sub-
scription for private treatment?

All of us should see a patient urgently if asked
to do so. If the next clinic is not soon enough
that the patient is for the first time in a new
arrangement, such as to admit the patient direct to the ward or
to send the patient to the accident and emergency
department, whose remit, surely, is emergencies.

Currie is lucky indeed if the pressure of his work
allows him to perform all his elective surgery within
six weeks; most of us still have waiting lists that are too
long. When patients mention that they are
insured it is because they assume (quite correctly)
that there will be a long wait for routine treatment.

One must have a warped sense of values if one feels
that one is being bribed. By treating such patients
privately, out of NHS hours, one is making space to
treat other patients more rapidly.

Currie talks of "tin pot surgery," but it is
surely up to each practitioner to be confident
that he or she practices in a safe environment.
I would not perform a major operation in a private hospital that was not set up to deal with the complications. Treating private patients in the NHS base brings money into the trust.

I believe that the NHS provides a good service. The reasons for paying a private subscription, however, are many and include being able to see a consultant of your choice (this is more difficult in the NHS since the advent of additional contractual referrals); to have your consultations and be treated promptly and conveniently and in pleasant surroundings (this does not happen in most NHS settings); to enjoy privacy (ditto); and to have a wide choice of edible food (ditto).

If Currie would not allow his family to be treated anywhere other than in his own NHS hospital then the local private hospitals must indeed be in a sorry state, as implied by the latest consultations. It is a shame that Currie has resigned from membership of the BMA at a time when great changes are occurring in his NHS and when the BMA surely needs all the support that it can get.

Consul<OMITTED>

Consultant plastic reconstructive and hand surgeon

A2. Blood donation—altruism

Editor,—The private sector facilities that David Currie describes in his article bear no resemblance to those of the not-for-profit trusts in which I work. The days when private treatment was restricted to minor surgery in "dubious nursing homes" are long past, and the private sector, at least in the south east of Britain, has expanded to cover almost every kind of medical and surgical contingency. Some private clinics are now provided that match and sometimes surpass those in the best NHS units. Of course there are good and bad units—and probably good and bad doctors—in both public and private sectors, and so, unlike Currie, I find it entirely understandable that some people wish to choose for themselves what they consider to be the best available care.

Although most doctors in Britain are committed to the NHS, many can appreciate the advantages of having a private sector in parallel with public facilities. I do not believe that the medical insurers, doctors, or, indeed, patients need be in the least bit apologetic about choosing to operate or be treated outside the NHS. With the advent of audit and accreditation it will not be long before private practice can be conducted only in properly accredited units, and I find it interesting that most hospitals already accredited by the King's Fund are in the independent sector.

Currie's article, in which he refers to his "breeding", "resentment," "enragement," and "spiteful satisfaction," amply testifies to his bigoted and perceptive; fortunately, both in editors and the general public have the freedom to choose whether to be influenced by him. Most, when inquiring about the benefits of private health care, will seek accurate and unbiased information before committing themselves to an opinion, a decision, or, indeed, a subscription.

Caring for older people

Caring for carers should be included in undergraduate curriculum

Editor,—In her article on carers who care for older people Anne F Travers states that carers need recognition, information, and support from the health professionals with whom they are in contact.1 A recent Gallup survey, however, showed that 45% of carers receive no help whatsoever in their caring role.2 Since there are an estimated six million carers in Britain, this represents an enormous number of carers not receiving the wellbeing of any organisation, is supporting. Travers's article offers suggestions that could be implemented in both primary and secondary care to improve support for carers, but I believe that medicine should be proactive at a much earlier stage, with specific teaching on carers, their needs, and sources of support being provided at undergraduate level.

The General Medical Council has recently highlighted the importance posed by chronic illness and disability in an increasingly elderly and disabled population.3 All doctors, regardless of their specialty, should have insight and experience of such care. Despite the council's latest recommendation that teaching on chronic illness and rehabilitation should be included in the undergraduate medical curriculum,4 the amount and content of such teaching in British medical schools is generally inadequate.5 The new undergraduate curriculum for Newcastle upon Tyne includes a four week rotation, "chronic illness and rehabilitation," which is mandatory. A session on caring for carers focuses on identifying carers and their needs and providing information and support. I wonder for carers are the how many (or, I suspect, how few) other medical schools provide such formal teaching.

In patients' and carers' opinions, doctors, especially general practitioners, still have a pivotal role in providing patients with advice and information,6 but does current undergraduate and postgraduate medical education adequately equip our doctors with the skills to support carers? The introduction of the Carers (Recognition and Services) Act 1995 will make assessment of carers by local authorities mandatory. Teaching medical students and junior doctors to identify, listen to, and take care of carers should follow a similar course.

Carers need financial assistance to buy help

Editor,—Having personal experience of being a long term carer and having seen some of my friends struggle to fulfil this role, I have become convinced that, while the endeavours of organisations and those who are well-intentioned, the only important thing that makes a difference is practical financial help.

The most effective way of ensuring that long term caring does not become a depressing and never-ending burden and hinder people to do it for you. However hard people try to tell you that it is a labour of love, sooner or later—if you are having to do everything for the person for whom you care—resentment and anger begin to take over. No amount of recognition, information, and moral support can substitute for a professionally trained person doing the daily work involved in looking after an incapacitated person. Professional carers can go home at the end of the day. Among carers are stuck in their duties and night for seven days a week.

Putting this burden on families is a cheap and nasty way of solving a difficult problem. Support groups, counselling, or a sympathetic ear do not ease the trauma of constantly changing the bed of a doubly incontinent parent, of having to feed...