Improving London's health service

EDITOR,—Virginia Bottomley's cure for the ills of London's health services promises adverse side effects for many of London's doctors and other health professionals, whether they work in the community or the hospital sector. It may well lead to a major exodus of general practitioners from the capital; this would have an effect opposite to the one Mrs Bottomley claims to seek. It is extremely difficult to provide a high standard of primary care in London, partly because of the social deprivation and poor local authority services. For this general practitioners are rewarded with an income below the national average and a level of frustration much above it.

There is considerable (?deliberate) confusion about the figures, but it seems that general practice and community services will receive about 4% extra revenue next year to help them prepare for the extra workload. Some general practitioners will also benefit from schemes to improve substandard premises; £170 million over six years has been promised for this (but only £10 million for 1993-4). Little of these paltry sums is likely to be new money, most being sliced off existing allocations. For most general practitioners a huge increase in workload and a decrease in job satisfaction will result from the closure of almost a quarter of London's hospital beds. At present good practices in inner London are having difficulty recruiting new partners. Existing partners may soon find the new strains too great to cope with and may choose to leave to avoid "burn out."

The impact of the Tomlinson report on hospital staff will be no less dramatic. Many senior and rising hospital staff will be faced with having to find another job. Where will these highly trained, expensively developed clinical and academic staff, who depend on their teams, go to? Some may find their way to suburban, provincial, or country destinations. Many will be driven into the private sector, to Saudi Arabia, or to North America or countries in the South. A few will go to Europe. It will be the most able who are recruited to better appointments. We fear that none of this will "make London better" for the patient.

Of course the structure and function of our medical services must change to meet—even better, to anticipate—changes in the patterns of disease and the emergence of new methods to deal with them.

Such planning requires continuing, adequately resourced, and interactive collaboration between the professional, technical, and management arms of the NHS. Calling in Sir Bernard Tomlinson to throw together a salvage package as market forces take their toll cannot replace the well resourced, experimentally oriented planning apparatus so vital to the long term health and development of a real national health service.

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1 Smith J. Improving London's health service. *BMJ* 1993;306:535-6. (27 February.)

2 Smith J. Government decides on fate of London's health care. *BMJ* 1993;306:537-8. (27 February.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

EDITOR,—Jane Smith's editorial on improving health care in London raises some important issues in relation to the London Implementation Group to which I wish to respond.¹ Smith questions whether the group will be able to explain what is happening to staff and patients and says that it "smells too much of hole in the corner deals."

As a former regional chairman I recognise the value and importance of open communication. Change is always hard but clearly is even harder if the reasons for it are not explained. I expect the improvements in services that Londoners should see in the coming years to speak for themselves, but there is no room for complacency. Silence and rumour are the enemies of understanding. That is why communications are a priority.

The London Implementation Group has a full time press officer working alongside colleagues in the Thames regions. We are also working hard to develop internal communication with staff. To that end we will be providing staff with up to date factual information, often through managers, who can keep staff briefed and explain the implications of the changes, not only for their hospital but for them individually. Two newsletters have already gone out to all staff, and these will continue in the months to come.

The London Implementation Group has no hidden agenda. It is an organisation by the NHS for the NHS. It is being led by Bob Nicholls, formerly the regional general manager of Oxford region. Its ethos is to work through existing organisations to bring about change. It is working hard to link with as many bodies as possible. Dr Peter Simpson, formerly regional medical officer in Mersey region, and Aina Fawcett Henesy, director of nursing in South East Thames region, have joined the group to ensure that it has open channels of communication with the professions. Its processes must be open if it is to win understanding and acceptance.

The human resources subgroup is being led by Charles Keaney, human resources director in North West Thames region. It is developing policies and protocols to assist managers in handling the staffing implications of the changes. The implementation group wants to work closely with the health unions and staff and professional organisations. Arrangements will include a clearing house to help match staff with vacancies and special provisions for retraining. There is also likely to be ring fencing of some key posts.

I do not underestimate the challenge that lies ahead for the London Implementation Group. I am confident that we can meet the challenge and will do so best by taking the professions, public, and staff with us.

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1 Smith J. Improving London's health service. *BMJ* 1993;306:535-6. (27 February.)

Priorities in first aid

EDITOR,—I wish to protest about some of the teaching in the latest edition of the *First Aid Manual* by the St John Ambulance, the St Andrew's Ambulance Association, and the British Red Cross.¹ Dealing with resuscitation, it instructs (p 32): "If the casualty's breathing *and* pulse [its italics] have stopped, you must *first* phone for help, *then* [my italics] combine artificial ventilation with chest compression." Similarly (p 61), first aiders are taught to begin the rescue of someone who has collapsed from fume and gas inhalation by going away to telephone.

The last words in the manual before the index read (p 232): "By legal definition, correct first aid practice is that which has been approved by the Voluntary Aid Societies for publication in this book, where this has been used in the training of the First Aider." That could be bad news for any theoretical widow suing a first aider who had left her husband to die while scouting around for a telephone. She and her legal advisers might aim further at those who produced the manual.

In the first aid world this manual is regarded as a sort of bible, and the fundamentalists (of whom there are many) may follow its text literally.

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1 St John Ambulance, St Andrew's Ambulance Association, British Red Cross. *First aid manual*. 6th ed. London: Dorling Kindersley, 1992.

**We sent this letter to the authors of the manual, who replied as follows.

EDITOR,—The three voluntary aid societies have received several inquiries similar to A S Playfair's questioning the dogma of the sixth edition of the *First Aid Manual*. For too long we have sat on the fence regarding when a lone rescuer should leave a collapsed victim to seek medical help. Obviously, when there is more than one rescuer there is no problem—one goes for help and the other stays with the patient. Recently, the importance of early access has been studied as a component of the chain of survival (early access, early basic life support, early defibrillation, early advanced care). The arguments about when to leave a casualty were addressed at the American Heart Association's national conference on cardiopulmonary resuscitation in 1992 and were rehearsed in detail in its proceedings.¹ The European Resuscitation Council agrees with the American Heart Association,² and the *First Aid Manual* has adopted its guidelines to present an internationally approved approach.

Before 1992 a lone rescuer was advised to perform cardiopulmonary resuscitation for some time before calling for help. Stults pointed out that trained rescuers who are on their own often delay calling an emergency service and may use neighbours and other bystanders rather than dialling immediately for an ambulance (the main source of a defibrillator).³ The window of opportunity for survival from sudden cardiac arrest is narrow,⁴ the best chance occurring when the emergency medical services are activated first so that a defibrillator can be brought in good time. It has been argued that this approach may delay treatment of a victim of obstructed airway or primary respiratory arrest. In practice, most

collapses outside hospital are due to cardiac arrest. In over 80% there is ventricular fibrillation, which carries a high chance of survival given early defibrillation. In practice, it is difficult for even trained rescuers to distinguish between a primary cardiac arrest and a collapse secondary to airway and breathing causes.

In a standardised approach to the immediate resuscitation of a casualty a quick assessment of the airway, breathing, and circulation (which includes opening the airway) should allow the first aider to decide whether the problem is unconsciousness alone, disturbed or absent breathing, or cardiac arrest. If both breathing and pulse are absent and the rescuer is alone the casualty is more likely to survive if the rescuer phones for help before starting cardiopulmonary resuscitation.

It is true that in the first aid world the manual is regarded as a sort of bible. Yet medicine is not a precise science and some treatments recommended, though they benefit most casualties, may occasionally be harmful. The first aid societies stand by their advice and believe that there is sufficient medical evidence to justify their statements in the unlikely event of a "theoretical widow suing a first aider."

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- 1 American Heart Association. Guidelines for cardiopulmonary resuscitation and emergency cardiac care. *JAMA* 1992;268: 2184-5.
- 2 Holmberg S for the European Resuscitation Council. Guidelines for basic life support. *Resuscitation* 1992;24:103-10.
- 3 Stults KR. Phone first. *Journal of Emergency Medical Services* 1987;12:28.
- 4 Cummins RO, Eisenberg MS, Hallstrom AP, Litwin PE. Survival of out-of-hospital cardiac arrest with early initiation of cardiopulmonary resuscitation. *Am J Emerg Med* 1985;3: 114-9.

Effect of NHS reforms on GPs' referral patterns

EDITOR,—Since the advent of the NHS reforms and the internal market, expedient treatment and patients' convenience often seem more important than quality of care. Purchasers who seek prompt treatment for their patients far from home are unlikely to receive the results of peer review audit in the treating unit. Abel-Smith has shown how this may lead to a discredited system.¹ The number of patients being treated far from their local provider unit is unknown, but referral to distant units is promoted by the NHS helpline established by the government.²

Although Angela Coulter and Jean Bradlow report no change in referral patterns in 16 general practices studied,³ we report a case that highlights the problems associated with patients travelling considerable distances for treatment of common conditions. A 64 year old man with bilateral inguinal hernias was seen in a surgical clinic and placed on the waiting list for elective hernia repair. He had had a congenital right inguinal hernia repaired as a child. Because of the length of the local waiting list (waiting time 6-9 months) the patient contacted the NHS helpline, which confirmed that a hospital in south Wales had spare operating capacity.

The patient arrived by train on a Wednesday, was operated on the next morning, and was discharged 24 hours later. Travel back to West Yorkshire entailed a five hour car journey. On arriving home the patient complained of discomfort in the left calf and pain in the left testicle. Over the next five days the testicle became more painful and swollen, and on the seventh postoperative night the patient woke with pleuritic chest pain. He was admitted to the general medical service at Pinderfields General Hospital with a provisional diagnosis of pulmonary embolism. In addition the

left testicle was hard, indurated, and tender. Exploration of the testicle was deferred because of the potentially life threatening medical condition. Doppler ultrasonography suggested infarction of the testicle, and phlebography confirmed venous thrombosis in the left calf.

This case raises concerns about the accuracy of audit data when patients are treated in this way. As the debate about contracting, fundholding, rationing, waiting list initiatives, and the patient's charter rages it is important to document the incidence of complications, which—unlike the primary condition—are often treated in local provider units. Though money may follow the patient, postoperative morbidity tends to stay at home.

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- 1 Abel-Smith B. Challenges for the NHS. *Hospital Update* 1993; 19(6):34.
- 2 Department of Health. *New health helpline*. London: DoH, 1993. (Circular H93/510.)
- 3 Coulter A, Bradlow J. Effect of NHS reforms on general practitioners' referral patterns. *BMJ* 1993;306:433-7. (13 February.)

EDITOR,—I am a patient in a London teaching hospital where medical staff have been told not to accept any extracontractual referrals until they have received confirmation that the patient's local health authority will fund that patient. I gather that they have also been told not to worry patients by explaining the real reasons for any consequent delay in treatment.

I consider such an instruction to be wholly misguided. It means that patients, in their ignorance, blame already overstressed medical staff for delays or treatment withheld while those who should be held accountable are cushioned from the consequence of their actions. We patients must be told the unpalatable facts so that we can exert pressure on those who really are responsible for prolonging our pain.

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EDITOR,—In their paper on the effect of the NHS reforms on general practitioners' referral patterns Angela Coulter and Jean Bradlow state that "the overriding impression is that referral patterns remained strikingly similar among both fundholders and non-fundholders."¹ This cannot be left unchallenged. Clearly, the purpose of including a non-fundholding group was to control for variables, including secular trends. The increase in referral rates in the fundholding group (from 107.3 to 111.4 referrals per 1000 patients a year) was much smaller than that seen in the non-fundholding (control) group (from 95.0 to 112.0).

Closer scrutiny of the data sheds further light on this comparative reduction in the referral rates of fundholders. Table IV shows that though for females the referral rate in the non-fundholding group increased from 111.1 to 130.5, the increase in the fundholding group was only from 127.8 to 128.9. For women aged 75 and over fundholders increased referrals by 2.2% whereas non-fundholders increased them by 20.3%. The age specific referral rate for women aged 65-74 decreased by 3.3% in the fundholding group, compared with an increase of 34.5% in the non-fundholding group.

The authors draw attention to the increase in fundholders' referral rates to general surgery (an 8.6% increase), but this should surely be interpreted in the light of the 17.0% increase in such referrals by non-fundholders (table III).

Although brief mention is made of a reduction in general medical referral rates, no attempt is made to compare this 9.8% reduction with the 22.6% increase in the non-fundholders' referral rate to general medicine.

Coulter and Bradlow conclude that "the overall increase in referral rates may seem disappointing to those who hoped that fundholding would provide a mechanism for reducing the demand for specialist care," but our interpretation differs. We suggest that there is considerable evidence in the data that they present for a downward pressure on referral rates, most noticeably in women (perhaps particularly in elderly women) and to the specialty of general medicine. Our only alternative explanation is that the higher referral rates in the fundholding group compared with non-fundholding group in the year before the introduction of fundholding represent an atypical year for these practices.

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- 1 Coulter A, Bradlow J. Effect of NHS reforms on general practitioners' referral patterns. *BMJ* 1993;306:433-7. (13 February.)

Authors have rights too

EDITOR,—Michael Dewey's plea for authors' rights¹ brought back painful memories, for we have recently suffered the writer's equivalent of torture at the hands of the editors of a journal published by the BMJ Publishing Group. Before drawing our conclusions we summarise the events.

We submitted a manuscript in August 1991 and revised it in October in the light of minor criticisms by the referee(s), whose report was highly supportive. The only request from the editor was that we should reduce the length of the paper. We were therefore taken aback to receive, within two weeks, a highly critical letter from the editor requesting a major restructuring of the paper and enclosing a heavily edited copy of the manuscript. We complied fully with the instructions and re-submitted the paper in January 1992. In February the editor made four new criticisms on technical matters, which we dealt with in a third revision. In May we received another referee's report and a letter from the new editor of the journal. This referee's report asked whether the paper was appropriate for the journal. A fourth revision, taking into account the new referee's technical comments, was submitted in June. The next month we received yet another set of referee's comments and a rejection of the paper on the grounds of its unsuitability for the journal yet complimentary in other respects. Our appeals were rejected.

We were hurt by the insulting tone of some of the written communications and puzzled as to why repeated telephone calls were never returned by the editors. We were dismayed to learn that the new editor was making decisions without access to the full file on our paper.

This series of events wasted thousands of pounds of public funds in terms of opportunity costs; caused embarrassment to us; has long delayed the publication of our work; has reduced the originality of the work as others have published papers on related topics in the intervening period; and has swept away our confidence in the editorial and peer review process. Our sense of injustice has been shared by three senior journal editors we have discussed the matter with.

Our recommendations are as follows:

- (1) The decision about a paper's suitability for the journal should be an early one, and no revisions should be requested until this decision has been made.