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.

MAREK KOPERSKI

Kentish Town Health Centre,
London NW5 2AJ

HARRY KEEN

United Medical and Dental Schools,
Guy's Campus,
London

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.

TIM CHESSELLS

London Implementation Group,
NHS Management Executive,
London WC1B 5EP

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.

A S PLAYFAIR

Cambridge CB2 2PS

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