Some patients were given volume loading to improve cardiac output after the application of positive end expiratory pressure. Without measurements of wedge pressure the volume of fluid required is difficult to assess, and clinical indicators of volume state in this type of patient are not accurate. In addition, to maintain optimal oxygen delivery and cardiac output in the face of a high positive end expiratory pressure it may be necessary to utilise vasoactive drugs. These drugs have unpredictable and sometimes deleterious effects on oxygen transport and respiratory function (particularly pulmonary venous admixture). Unless mixed venous oxygen saturation and oxygen consumption are monitored these effects, which may make tissue hypoxia worse, will be missed.

We agree that the study of Drs Singer and Bennett confirms the need for haemodynamic monitoring. Measurements should also be made to ensure that optimal global oxygen transport has been achieved, which, with our present understanding and technical skill, will necessitate pulmonary artery catheterisation.

GRAHAM R NIMMO

Medical Renal Unit,
Department of Medicine,
Royal Infirmary, Edinburgh EH3 9YW

SUSAN M STEWART

Department of Anaesthetics,
Royal Infirmary, Edinburgh EH3 9YW

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Hearing loss in the elderly

SIR,—The prevalence of deafness reported by Dr J K Anand and Ms Ivy Court¹ is similar to that of 42% reported by Townsend and Wedderburn² nearly 30 years before in institutionalised patients over 65.

The hearing aid services in many health authorities already have long waiting lists, and so further selection of at risk populations would help to maximise resources. We have recently assessed the hearing of patients aged over 65 who presented to the ophthalmology clinic with senile visual degeneration (for example, cataract or macular degeneration) and found that 12 out of 25 patients had appreciably impaired hearing (that is, over 30 dBA hearing loss in the better hearing ear) on testing by pure tone audiometry.

This group of patients also deserves special priority for audiological rehabilitation because they are already disabled by their visual handicap, which adds to their social isolation. This is particularly relevant in areas where the waiting list for providing a hearing aid is far in excess of the four weeks quoted by Dr Anand and Ms Court,³ and we recommend further work to identify other specific groups to move audiological rehabilitation to a more proactive service.

P GERARD REILLY
A NARULA

Department of Otolaryngology,
Queen's Medical Centre,
Nottingham NG7 2UH

- 1 Anand JK, Court I. Hearing loss leading to impaired ability to communicate in residents of homes for the elderly. *Br Med J* 1989;298:1429-30. (27 May.)
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Neck sprains after car accidents

SIR,—Despite the many statistics he presented, I was surprised that Dr K M Porter did not entertain the possibility that the symptoms of a neck sprain may be related to secondary gain.¹

While there is no doubt that patients can injure their necks in motor vehicle accidents, the very large variation in the incidence of whiplash injuries in different countries suggests that secondary gain may be an important feature in the development and prolongation of symptoms of this disorder. A study comparing the incidence of neck sprains in Australia and New Zealand found that there were 10 times as many neck sprains in the state of Victoria as there were in New Zealand, two areas with essentially similar populations.² The number of motor vehicle accidents and the number of rear end accidents were similar in both population groups. The amount of compensation paid in the state of Victoria was three times higher than that paid in New Zealand because New Zealand has a no fault accident compensation system.

GEOFFREY HORNE

Department of Surgery,
Wellington Hospital,
Wellington,
New Zealand

- 1 Porter KM. Neck sprains after car accidents. *Br Med J* 1989;298:973-4. (15 April.)
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Non-attendance or non-invitation?

SIR,—The paper by Dr S Frankel and colleagues on non-attendance at outpatient clinics is a valuable work of audit which is relevant to all clinical specialties.¹ They found that 52% of non-attenders—that is, patients on holiday, who had decided that treatment was unnecessary, or who had difficulty getting time off from work—could potentially have contacted the hospital in advance to allow the appointment slot to be reallocated.

My clinical impression is that an appreciable number of both new and follow up patients do try to postpone or cancel appointments if they realise in advance that the time is unsuitable. This is usually done by telephone, but some telephone systems in large hospitals are so inadequate that the patients give up trying in frustration. This frustration can also afflict health professionals, who waste considerable time trying to phone in to colleagues or departments in hospital. I would be interested to learn if the six page questionnaire was able to shed any light on the effects of this type of administrative delay both in general and on the repeat non-attenders.

I A DAVIDSON

Royal Liverpool Hospital,
Liverpool L7 8XP

- 1 Frankel S, Farrow A, West W. Non-attendance or non-invitation? A case-control study of failed outpatient appointments. *Br Med J* 1989;298:1343-5. (20 May.)

AUTHORS' REPLY.—Dr Davidson points to another important administrative problem that can have the effect of causing patients to appear to be more responsible for non-attendance rates than they may truly be. We did ask about attempts to contact the hospital, and 64% of the 277 non-attenders stated that they had contacted the hospital, of whom 31% stated that they had given one week's notice, 26% that they had given four to six days' notice, and 29% one to three days' notice. At the very least it seems that a proportion of non-attenders had taken reasonable measures to permit their unwanted slot to be used. Of patients who contacted the hospital, 57% reported doing so by telephone and half of

those reported considerable difficulty in getting through. It is likely that a proportion of those who did not contact the hospital attempted to telephone but gave up the task. As we said in our paper, it is important to seek practical and soluble explanations for health service problems. A telephone exchange can be modified fairly easily. Such improvements in management or organisation are less likely to be sought where failings in the health service are attributed too readily to uncooperative patients.

STEPHEN FRANKEL
ROBERT WEST
ALEXANDRA FARROW

Department of Epidemiology and Community Medicine,
University of Wales College of Medicine,
Cardiff CF4 4XN

Disimpaction of swallowed bolus

SIR,—We agree with Drs P T Ignotus and A Grundy that carbonated drinks can safely and quickly disimpact a food bolus lodged in the lower oesophagus and were pleased to see their single case report in your widely read journal.¹ Previous accounts of the successful treatment of eight patients² and 16 patients³ have been reported in radiological journals.

The use of the effervescent granules normally used in double contrast studies is a convenient way to administer the fizzy drink and was described by this department in 1986.⁴ We have continued to use the technique with success. We have encountered no complications, have avoided endoscopic removal on several occasions, and commend it to others.

N CAMPBELL
P A SYKES

Trafford General Hospital,
Manchester M31 3SL

- 1 Ignotus PT, Grundy A. Disimpaction of swallowed bolus. *Br Med J* 1989;298:1359. (20 May.)
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Standards of wheelchairs

SIR,—Dr G P Mulley's article is a timely reminder to those of us working in hospitals that the wheelchairs used for transporting patients within hospitals should be of a sufficient standard to meet the requirements of the Health and Safety at Work Act.¹ The problem of inadequate, poorly maintained, and incomplete wheelchairs in hospitals is well known,^{2,3} and fewer than a quarter of hospital wheelchairs are safe and in good working order. Since the lifting of crown immunity hospitals need to look carefully at their wheelchairs to ensure that they do not contravene the Health and Safety at Work Act. The DHSS issued a safety bulletin in May 1985⁴ and recommended that wheelchairs be inspected regularly and maintained in a safe and clean condition.⁵ In most hospitals this is clearly not the case.

Dr Mulley suggests that hospitals should appoint a wheelchair team to ensure that staff are taught more about the problems of wheelchairs and their users and that wheelchairs are regularly inspected, maintained, and cleaned. At Stoke Mandeville Hospital the wheelchair committee has recently published a wheelchair policy that includes policy on portering wheelchairs, ward based wheelchairs, department and clinic wheelchairs, occupational therapy and physiotherapy loan and assessment

wheelchairs, and wheelchairs required for short term loan. It includes maintenance and cleaning procedures and guidance on providing cushions and establishes who is responsible for each group of wheelchairs. The hospital is about to replace its antiquated stock of ward based and portering wheelchairs with new ones, chosen to meet specifications written by the wheelchair committee. Unfortunately, not many hospitals will find themselves in such a privileged position with regard to their trust funds. This financial provision should, however, be weighed up against any possible claim against the hospital due to the inadequacy of its wheelchairs.

All hospital wheelchairs should be distinctive in colour, colour coded according to their use and geographical area, and clearly marked with a hospital identification number. It is important to remember that hospital wheelchairs are used not only for transporting patients; some patients are required to sit in them for up to eight hours continuously. This not only causes considerable discomfort but may also lead to ischial pressure sores.⁵

ROMY CREWE

Stoke Mandeville Hospital,
Aylesbury, Buckinghamshire HP21 8AL

- 1 Mulley GP. Standards of wheelchairs. *Br Med J* 1989;298:1198-9. (6 May.)
- 2 Young JB, Elfield PW, Mascie-Taylor BH, Mulley GP. The neglected hospital wheelchair. *Br Med J* 1985;291:1388-9.
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How to be a manager

SIR,—“There is no right or wrong way to learn how to be a manager”¹ would have been a suitable epitaph for British management had not the value of proper training been realised in the 1960s with the establishment of several centres of excellence for business education such as the London Business School.

The central qualification that may be attained at these schools is a master's degree in business administration, which is recognised and highly valued by both private and public sector organisations world wide, not least by acknowledged leaders in both production and service industries.

Several doctors now have an MBA, having recognised that the central concept of business school programmes is valid—that is, that management can be taught as a unified body of essential knowledge that may be applied to any organisation, including the NHS. Many lessons from industry transfer readily to the NHS; after all, good management simply means the production of a quality service or product within the confines of limited resources, and this applies equally well to the NHS.

We have had numerous requests from doctors for guidance on how to develop management skills. They recognise that reading a book or two on the subject is not enough; they want and require a substantial business training. The MBA course offers them a thorough grounding in the whole range of management functions such as developing skills in analysis, problem solving, and decision making and access to new knowledge and insights into the nature and process of management.

Doctors who have the degree often comment that their colleagues who lack business training seem to be reinventing management concepts. For example, the concept of quality assurance has been the foundation of the success of Japanese industry for decades, yet its implementation has only recently been discovered by most doctors and renamed medical audit.

Quality assurance can have a profound impact on hospital costs. The consensus opinion at a recent international congress on quality assurance in health care in Amsterdam sponsored by the Joint Commission and the International Hospital Federation was that “getting it right first time” in clinical settings produces an appreciable reduction in costs.

When considering how to deal with overspending, as in Dr Chantler's example of Guy's Hospital, there are many alternatives to straight cuts in staff. Virtually all hospitals face high staff costs, but others have turned to more imaginative solutions such as income generation projects, asset utilisation review, and improved staff scheduling. It is difficult to make the best decision about using assets and capital budgeting without a thorough understanding of the concepts of opportunity cost, the time value of money, the capital asset pricing model, and methods for measuring risk, concepts that are not mentioned in books or the medical curriculum.

If and when self governing hospitals come about, according to the Canadian model the hospitals that achieve the lowest cost combined with the highest quality of service will be those to prosper to the benefit of patients. Their management boards will require doctors with astute business brains and refined management skills; only such staff will be best able to select optimal business decisions with a suitable concern for quality of clinical care.

The greatest physicians and surgeons of our time are those who do not profess always to know the answer to every problem. There is a danger that this maxim will be forgotten if doctors take on the management mantle with the belief that they already possess all the necessary skills. As President Truman once commented: “It's what you learn after you know it all that counts.”

PETER WALTON

Medical Association for Masters of Business Administration,
London N1 1DB

- 1 Chantler C. How to do it: be a manager. *Br Med J* 1989;298:1505-8. (3 June.)

SIR,—Though I agree with much of what Professor Cyril Chantler propounds,¹ as someone who has spent many years helping doctors to become proficient in management I would like to comment on the need for training.

It is true that the role of a clinician incorporates managerial functions—that is, self management, patient management, staff management, and service management—but a medical degree does not automatically give doctors the ability to fulfil them. In fact, medical training largely ignores the existence of a well established and authenticated body of knowledge and associated attributes that comprise management skill; consequently, with notable exceptions, doctors are ill prepared for management.

In the present climate and with the prospect of self governing hospitals looming large on the horizon it is absolutely imperative that clinicians become skilled managers if they are to maximise their contribution. Intelligence, though a prerequisite for managerial competence, is no guarantee of inherent ability. Management skill is definitely not a natural human aptitude and needs to be developed and nurtured.

The prime skills of effective managers are those needed to work collaboratively with people individually and in teams and groups to achieve organisational objectives. Their acquisition requires participation in systematic, formal training programmes. If we want to ensure that clinicians become effective managers in providing for the needs of their patients management education must become an integral component of all undergraduate and postgraduate medical training. We

can no longer afford to continue to rely solely on the provision of postgraduate short courses to meet this need, excellent though they may be.

FRADA ESKIN

Sheffield S10 3FN

- 1 Chantler C. How to do it. Be a manager. *Br Med J* 1989;298:1505-8. (3 June.)

Informed consent and medical information for insurance companies

SIR,—As a physician with consulting status to several major life insurance companies, I am naturally concerned that so many clients were unaware that in applying for life assurance before 31 December 1988 they had signed a declaration allowing any medical evidence to be obtained from any doctor.¹ I accept that the information may have been in small print at the bottom of the forms and may have escaped attention. However, Dr Robert E Lorge fails to take any account of the Access to Medical Reports Act 1988, which came into effect on 1 January 1989 and establishes applicants' right of access to reports on themselves provided by medical practitioners for employment or insurance purposes.

All insurance companies now have to have a specific form signed by the applicant allowing any medical report to be made available to them. The applicants also have the right to see any report, and amend it if they see fit, before it is sent. If they do not wish to see the report they can indicate this on the consent form. Thus, the situation has changed from the time when Dr Lorge probably collected his data.

Dr Lorge also cites a study which showed that half the patients attending a clinic for AIDS did not wish their general practitioner to be informed because they feared disclosure to insurance companies. This implies that they might wish to apply for life insurance while knowing that they are suffering from AIDS, which is dishonest and not in the public interest, as the reason for selecting against patients suffering from AIDS, or indeed those who are HIV positive, is to protect the premiums and policies of the vast majority of the unaffected public.

R J COURTENAY-EVANS

Purley and District War Memorial Hospital,
Purley CR2 2YL

- 1 Lorge RE. How informed is patients' consent to release of medical information to insurance companies? *Br Med J* 1989;298:1495-6. (3 June.)

Insurance medical reports

SIR,—I am writing about the article by Dr Robert E Lorge on patients' consent to the release of medical information to insurance companies¹ and the editorial by Dr John D Beale.²

A considerable interval can occur between an applicant completing the original proposal form and a general practitioner being asked for a report, presumably therefore still longer before the applicant might have received Dr Lorge's questionnaire; this information is not given. Had the question “Did Dr Lorge give you any advice at your last visit to him?” been put after similar intervals it might well have produced somewhat analogous results. If he found that many of his patients genuinely did not understand what they were signing I am sure Dr Lorge would be adding to the advice which he gives them by stressing the folly of signing that or any other document without having carefully read and understood it.

I understand the desirability of designing