and the Department of Health with accident compensation statistics is clearly necessary if adequate data are to be used in preventing accidents.

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- 1 Teanby D. Underreporting of pedestrian road accidents. *BMJ* 1992;304:422. (15 February.)
- 2 Morrison PJ, Kjellstrom T. A comparison of hospital admissions data and official government statistics of serious traffic accident injuries. *NZ Med J* 1987;100:517-20.

Home visits by psychiatrists

SIR,—Christine Hardy-Thompson and colleagues report general practitioners' views on psycho-geriatric domiciliary consultations.¹ We recently submitted for publication a report of a study evaluating the cost of psychiatric outpatient consultations and what the costs of home consultations would be if all such outpatients were seen at home. The cost of psychiatric outpatient consultations in England for 1989 was estimated as £205 882 529 and that for home consultations as £215 326 723. The main reason for the costs being similar despite the extra time spent travelling for home visits was the high non-attendance rate (up to 38%²) in the outpatient clinic.

Assessing patients at home has several advantages. The consultation rate is almost 100%. The patient's home environment can be observed at first hand rather than information on it obtained from the patient or an informant at the clinic. Unnecessary social work and occupational therapy assessments, which may otherwise be requested by the outpatient clinic are avoided. The psychiatrist has ready access to the patient's medication, which is often not brought to the clinic. This draws attention to polypharmacy, poor compliance, possible interaction with non-psychotropic drugs, hoarding for overdose, and dependence on benzodiazepines. The stigma of attending a psychiatric clinic is reduced.

Given these advantages and that home consultations are only marginally more expensive than outpatient consultations, we should be looking at placing greater emphasis on home consultations. Some psycho-geriatric services have almost done away with outpatient clinics in favour of home visits. This to some extent will reduce the importance of the indications for domiciliary consultations.

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- 1 Hardy-Thompson C, Orrell MW, Bergmann K. Evaluating a psycho-geriatric domiciliary visit service: views of general practitioners. *BMJ* 1992;304:421-2. (15 February.)
- 2 Shah AK, Lynch S. The characteristics of patients attending a psychiatric follow-up clinic. *Psychiatric Bulletin* 1990;14:153-4.

Fundamental principles of the NHS

SIR,—A consensus is now emerging that general practitioners can be effective commissioners of secondary care, and there is concern as to how the commissioning role can be efficiently extended to the whole of general practice. The fact is that fundholders in general practice, by redefining their relationship with their consultant colleagues, exploiting the flexibility that their small volumes of work allow them, and combining their knowledge of patients' needs with their knowledge of pro-

viders' capabilities, can be more effective commissioners of care than health authorities.

With further expansion of the fundholding scheme several serious issues need considering. How can contractors cope with multiple purchasers? Is the increased management cost justified? How will family health services authorities and regional health authorities effectively monitor an expanded scheme? Will all practices perform efficiently as commissioners of care? What will the effect be on district health authorities and purchasing consortiums? How can general practitioners' purchasing plans be integrated within the strategic framework developed by health authorities? What is the role of the general practitioner to be?

These questions are complex, and the profession needs to develop answers as, no matter what the political environment, the issues will remain. Fundholding has shown that general practitioners, acting as the patients' agent, can deliver an improved service. How can this be spread to the rest of our colleagues?

The stark choice facing us is between rationing by restricting the range of services provided by the NHS or improving the efficiency of the service, as J B L Howell points out.¹ We should all consider how those efficiency gains can be achieved.

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- 1 Howell JBL. Re-examining the fundamental principles of the NHS. *BMJ* 1992;304:297-9. (1 February.)

SIR,—Disconcertingly, in J B L Howell's article¹ the duties of the minister of health specified in the NHS Act of 1946 tailed off into a row of dots just before the word "rehabilitation" occurred in the original. Sir Donald Acheson has recently reminded us that Beveridge's three legged stool of the NHS specified prevention, treatment, and rehabilitation. It is surely a fundamental principle of three legged stools that the shorter one leg gets in comparison with the others, the more uncomfortable the stool becomes. There is a great deal of catching up to be done in the development of our rehabilitation services before we can claim to be back in alignment with the fundamental principles of the NHS.

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- 1 Howell JBL. Re-examining the fundamental principles of the NHS. *BMJ* 1992;304:277-9. (1 February.)

Prescribing at the hospital-general practice interface

SIR,—My recent research leads me to concur with Roger Jones and Michael Rawlins that communication is singularly important for quality of care at the interface between hospitals and general practitioners.¹

I conducted qualitative research, interviewing 21 general practitioners from nine local non-fundholding practices. My objective was to identify the real concerns of general practitioners with regard to prescribing issues at the interface. My findings in order of importance as perceived by general practitioners are as follows.

Firstly, the promptness and quality of communication from hospitals to general practitioners about prescribing was criticised. Though patients received seven days' supply of drugs on discharge, they often attended the surgery well within this time to request continuation of treatment. Thus in many cases the general practitioner was being

asked to prescribe without adequate information. The clarity and amount of information were said to need attention. General practitioners wanted to know the intended duration of treatment and the reasons for interventions.

Secondly, the interviewees were concerned that clinical responsibility was unclear. Views varied widely, including, "The hospital should provide the general practitioner with information to prescribe complex drug regimens" and, "The hospital must share clinical responsibility if the general practitioner prescribes for the hospital."

Thirdly, there was a general feeling that it was unfair to levy a prescription charge for two weeks' treatment. Some "more experienced" patients go direct from the outpatient department to the general practitioner, knowing that they may obtain one month's supply.

Fourthly, loss leaders to the hospital service were frequently mentioned, though this was considered comparatively less contentious.

Fifthly, the general practitioners often mentioned that an intervention in treatment while the patient was in hospital had not been explained to them.

Finally, some of the general practitioners considered that the system of returning patients' own drugs, taken into hospital for a drug history, was not working adequately, leading to potential wastage.

These concerns are now being addressed locally; I believe that general practitioners in other areas may have similar concerns. I thus recommend that those concerned in compiling hospital drug protocols should involve local general practitioners both through liaison committees and by a direct personal approach. Patients should be informed of the communication process and its timescale.

I believe that the recent NHS reforms and an executive letter^{2,3} now give us the opportunity to improve the quality of care across the interface between hospitals and general practitioners. There is no need to wait for any merging of district health authorities and family health services authorities or changes allowing virement between budgets before starting initiatives.

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- 1 Jones R, Rawlins MD. Prescribing at the interface between hospitals and general practitioners. *BMJ* 1992;304:4-5. (4 January.)
- 2 NHS Management Executive. *Responsibility for prescribing between hospitals and GPs*. London: Department of Health, 1991. (EL(91)127.)
- 3 Welsh Office. *Responsibility for prescribing between hospitals and GPs*. Cardiff: Welsh Office, 1991. (WHC(91)94.)

One car down

SIR,—R S Bhopal's article on car ownership was thoughtful and provocative,¹ but its focus was on what individuals can do by and for themselves. Another set of questions must be asked about what health authorities, NHS trusts, and directly managed provider units could do to discourage unnecessary car use and so contribute to a greener NHS.

Possible ways to discourage use of cars include (1) increasing cycle mileage rates to near those for cars. This would encourage staff to use cycles for work by allowing them to make a small profit. (2) Giving free on site car parking spaces to staff (regardless of status) only if they need to use their car during working time. Many hospitals automatically give consultants free car parking spaces when they need their car only for travel to and from work. (3) Where on site car parking is charged for, to do so on the basis of engine size. (4) Providing secure cycle racks at the expense of car parking spaces. (5) Giving loans for public

transport season tickets. (6) Not providing staff with lease cars unless they need a car for work.

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1 Bhopal RS. One car down. *BMJ* 1992;304:451-2. (15 February.)

On your bikes

SIR,—To explore how to pursue the dual public health objectives of encouraging more cycling and promoting safer cycling¹ I undertook a survey of university students in Manchester in December 1989. I randomly selected 266 students from the 2110 residents of two halls and sent questionnaires. The only important difference between the hall residents and the total student population was that 70% of the hall residents were first year undergraduates compared with 36% of all students.

Completed questionnaires were returned by 208 students (78% response rate); 135 were cyclists, 56 of whom cycled in Manchester and 79 elsewhere. Seventy three said they never cycled. Those not cycling in Manchester (152) were asked to give reasons why not—up to three reasons per respondent. The commonest reason was that cycling in Manchester was too dangerous (104 respondents) and the second commonest that the chance of having a bike stolen was too high (93). Sixty one students indicated that cycling in Manchester would be “too unpleasant” (referring mainly to volume of traffic and fumes).

When asked to choose the most important ways to improve cycle safety from a list of suggestions 199 selected provision of cycle paths, 147 educating car and other drivers to drive more carefully with respect to cyclists, and 73 encouraging cyclists to wear helmets. One question asked: “If cycle helmets were made compulsory by law would you be more or less likely to cycle?” Seven students said they would be more likely to cycle, but 58 respondents (29%, 95% confidence interval 23% to 35%) said they would be less likely to do so. There was no significant difference between the cyclists and non-cyclists.

My results are consistent with the view that the perceived danger of cycling is one of the major deterrents to cycling. The respondents identified separate cycle lanes and changing driving habits as the most important ways of improving cycle safety. Helmets were generally perceived as being effective (results not reported here), but making them compulsory, as has been suggested,² would be another deterrent to cycling for around a quarter of students. Interestingly, the fear of having a bike stolen was also cited as an important deterrent. Public policy to encourage cycling should also aim at ensuring adequate provision of secure cycle parks, which are an important feature of some of the integrated public transport systems in Germany.³

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1 Godlee F. On your bikes. *BMJ* 1992;304:588-9. (7 March.)

2 *Accident prevention—a social responsibility*. London: Royal College of Surgeons of London, 1989.

3 Brunsing J. Public transport and cycling: experience of modal integration in West Germany. In: Trolay R, ed. *The greening of urban transport: planning for walking and cycling in Western cities*. London: Belhaven Press, 1990.

Doctors' contribution to environmental health

SIR,—If doctors are to contribute appreciably to environmental health it will have to be on the basis of inputs that cannot be made by the many other professionals, expert lay people, and agencies who have an interest in the environment.¹ Doctors' skill

lies in monitoring the environment and applying legislation. Our job is to identify and investigate effects on health, assess risks to health, improve the system of environmental control, and advance environmental policies to promote health. We also have a role in environmental education.

Medicine lacks a role in environmental health: Skill tends to be scarce and national, tied to long term activities, and lacking the flexibility and contacts to respond quickly to local problems. It is at a local, probably regional, level that developments are needed on four fronts.

Firstly, epidemiological skills (beyond the basic level provided by training in public health medicine) are needed so that medical advice is based on scientific argument. Rose pointed out “where dose response curves are considered to be linear or threshold-free, then it is the total emissions which need to be controlled, since many people exposed to a small risk may generate a large total of cases, albeit with no conspicuous risk to any one person or group. Yet much legislation is focused on protecting individuals from conspicuous and hazardous levels of exposure.”² Doctors should pursue this argument to its logical conclusion and challenge the attitude that current legal limits are unchangeable.

Secondly, information should be collated from the disparate published scientific papers, technical documents, and local and national reports and from the many multidisciplinary meetings on environmental issues, many of which charge admission at commercial rates.

Thirdly, a local infrastructure is needed to make use of whatever skill is available. The obvious person to coordinate activities is the director of public health, who has a unique platform for commenting and acting on environmental health issues, access to health information, and epidemiological and health promotion skills. Links are also needed with colleagues in occupational health. Public health medicine will, however, need to extricate itself from the task of wholly serving the management of the NHS and to set aside time for environmental health that is not continually raided by the demands of controlling communicable diseases.

Fourthly, where will resources come from? Do general managers in the health service see it as their business to finance “green offices” within departments of public health? Or should the polluter pay? To date, this principle has been applied only to environmental monitoring.

Delamothe's editorial should prompt a debate on these issues.¹

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1 Delamothe T. Airs, waters, places, and doctors. *BMJ* 1992;304:268-9. (1 February.)

2 Rose G. Environmental health: problems and prospects. *J R Coll Physicians Lond* 1991;25:48-52.

Changing to dry powder inhalation systems

SIR,—Susan Mayer and Andrew Haines's letter about ozone depletion and ultraviolet B radiation¹ prompts me to report my practice's experience with a changeover to dry powder inhalation systems.

About 18 months ago we almost instantaneously changed from using aerosols powered by chlorofluorocarbons to the Disk system, with Turbohalers and Spinhalers as back ups. Many patients commented on the increased benefit they received from the new devices, and roughly the same number bemoaned the loss of the simplicity of the aerosols. Our local pharmacist reports that he dispenses about two aerosols a month now, and the practice does not dispense any save to the occasional

temporary resident. As far as I know there is no ipratropium dry powder system yet, which is a small drawback. Our prescribing analysis and cost (PACT) figures for respiratory treatment are huge.

Such a change is easy to make: the customers either approve or acclimatise, and it might just be life saving—in the larger sense.

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1 Mayer S, Haines A. Airs, waters, places, and doctors. *BMJ* 1992;304:502. (22 February.)

Action Asthma: privatising the airways?

SIR,—In his letter Andrew Herxheimer alludes to a “national telephone asthma helpline,” and the mention of this in a letter about Action Asthma may lead to confusion. Though Allen and Hanburys does run a medical information service and may sometimes answer patients' inquiries, the most widely known asthma helpline is that run by the National Asthma Campaign. This is totally independent and staffed by four fully trained asthma nurses between 1 pm and 9 pm on Monday to Friday; it costs the price of a local call.

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1 Herxheimer A. Action Asthma: privatising the airways? *BMJ* 1992;304:505. (22 February.)

Medical arbitration

SIR,—We are involved in medical arbitration and in providing advice to medical arbitrators. Though a substantial number of arbitrations concerning medical issues take place, and frequently with a medical practitioner as arbitrator, there is no association or society of medical arbitrators. Further, the Chartered Institute of Arbitrators, which promotes arbitration generally, has no section devoted to medical arbitration.

If medical arbitration is to prosper—and we gather from recent announcements by the secretary of state for health that the government considers that it should—the training and appointment of medical arbitrators must be regularised. The most satisfactory method of achieving this would be to form an association of medical arbitrators, which could provide training programmes and maintain a panel of suitably qualified and experienced medical practitioners from which appointments could be made as required. Such an association could either affiliate itself to the Chartered Institute of Arbitrators or pursue its own course.

We would be interested to hear from medical practitioners, whether experienced in arbitration or merely interested in it, whether an association of the type we envisage should be set up. If sufficient interest is shown we intend to organise a meeting of those who have responded to discuss how matters might be moved forward. Any correspondence should be sent to Dr Douglas L Woolf.

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