Sen's editorial,¹ may well be due to tuberculosis; rates there now are comparable with those in the United Kingdom during part of the last century. Tuberculosis is, to a great extent, a disease of social deprivation, and thus Sen's point is valid. For some reason, however, young females have a higher mortality from tuberculosis than their male peers; this phenomenon is not yet understood and may account for at least some of Sen's missing women.

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1 Sen A. Missing women. *BMJ* 1992;304:587-8. (7 March.)

Tibial fixation

SIR,—The tibial hardware shown in a radiograph on Minerva's page¹ is almost certainly a Parham's band, well described as "the sort of clamp used to tie up electrical cables." I remember being shown it in a surgical instrument seminar as a medical student at Aberdeen Royal Infirmary in the late 1930s. One elderly surgeon still used it for oblique shaft fractures in long bones, but most of our teachers regarded it as a museum piece.

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1 Somerville DW. [Tibial x ray.] *BMJ* 1992;304:650. (7 March.)

Starting date of house officer posts

SIR,—It always strikes me as inefficient and dangerous that house officer posts start on the first day of the month, even if this falls on a Friday or a weekend, when there is likely to be least supervision of these inexperienced doctors.

Since there is more support from middle grade doctors and consultants during a weekday and since we tend to think about the week as running from Monday to Sunday, would it not be much more sensible to have house officers starting their posts on, say, the Monday after the first day of the relevant month? Bank holiday Mondays would not interfere with this plan for February and August, when the bulk of job changes occur, but would be awkward in May. No doubt local arrangements could be made in that case.

This plan has met with approval from the paediatric department at this hospital, but we would be unable to introduce it without cooperation from other hospitals from which doctors are likely to come since this may introduce a gap or overlap between appointments. Hence I write to you as a wider forum for suggesting this simple but useful change in the employment of house officers.

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SIR,—1 February has been and gone; hospitals around the country have coped with the influx of new doctors. For a good proportion of the doctors who have changed jobs the start of February will have meant a change of specialty or of hospital, or both.

1 February was a Saturday. I doubt that many hospitals managed to run an induction course that day, so many juniors will have found themselves on call for a strange unit in a strange hospital, relying on the good will of those around them to cope with the routine and emergency tasks put before them.

Little wonder that mortality figures in hospitals show a small blip in February and August.

The safety of patients aside, the Saturday changeover had one advantage. Apart from those poor souls who spent the weekend on duty, the rest of us had the whole weekend in which to move our home. Admittedly, few doctors move an appreciable distance between jobs, but for them the usual state of affairs—when the first of the month falls in the middle of the week—is to finish in one hospital at (they hope) 5 pm and have just 16 hours before starting the new job elsewhere. It is difficult to move home, spouse, and two small children from Plymouth to Glasgow on a Tuesday night, but somewhere out there will be a junior doctor who had to manage it.

There is a better way. Why could we not start new jobs on the first Monday of the month? This would guarantee that the new juniors arriving at a department would have five full days to get used to things before they had to cope with a weekend on call, the weekend being the time when the average hospital provides the least back up for junior staff. It would allow most doctors the whole weekend in which to move. Induction courses would always be on a Monday, making planning simpler. Domestic staff would have more time to clean rooms. Staff would arrive with time to spare and might even look around the wards to find out what awaited them on Monday morning.

It is time that this illogical, inconsiderate, and inconvenient tradition was replaced. A single directive from the General Medical Council or Department of Health could have the new system in force in time for August: why not?

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Outcome measures should be relevant

SIR,—The measurement of health outcomes is necessary for research, the assessment of innovations in services, and audit of established services. This is especially true for chronic conditions, for which traditional measures of success or failure in management, such as death or cure rates, are inappropriate, and for strategic management, in which the relative effects of widely differing conditions and interventions must be compared.

Alison Frater and David Costain's editorial is to be welcomed for reiterating these points,¹ but caution is needed. The medical outcomes study short-form general health survey, which Frater and Costain describe, is only one of a growing number of generic general health measures.² Although it is able to discriminate between different medical conditions, a more pressing need is to show sensitivity to change due to intervention.

The scale in the medical outcomes study describes a "profile" with six different scores being given for physical functioning, role functioning, mental health, and so on. The purchaser who wants to compare psychiatric inpatient care with hip replacement operations may have to trade off effects in different dimensions. Is a 10 point improvement in social functioning better than a five point improvement in health perceptions? A valid summary score to resolve this remains elusive, for this or any other general health scale.

Outcome measures need to be relevant to the objectives of the intervention. The four point New York Heart Association classification was used successfully to show improved functional abilities in the cooperative north Scandinavian enalapril survival study (a trial of enalapril in heart failure)³ but would have been inadequate for a trial of a new antidepressant agent. An unsuitable generic scale

used in a trial of NHS nursing homes failed to detect important differences shown by more suitable scales.⁴ The management of many chronic medical conditions depends on rehabilitation. This entails reducing disability by helping patients to reacquire lost skills and teaching new ones, providing aids and adapting patients' environment, psychological readjustment, involving the family and carers, and appropriate resettlement in suitable accommodation. These activities can be summarised as the reduction of handicap, the disadvantage that results from ill health.⁵ No adequate measure of handicap exists. Generic outcome measures may be insensitive to the effects of such interventions or may be only proxy measures while in fact measuring depression.⁶

Measurement of health outcomes will be a useful advance so long as valid, reliable, sensitive, and relevant scales are used. Some disease specific scales will remain useful.

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- 1 Frater A, Costain D. Any better? Outcome measures in medical audit. *BMJ* 1992;304:519-20. (29 February.)
- 2 McDowell I, Newell C. *Measuring health. A guide to rating scales and questionnaires*. New York: Oxford University Press, 1987.
- 3 CONSENSUS Trial Study Group. Effects of enalapril on mortality in severe congestive heart failure. *N Engl J Med* 1987;316:1429-35.
- 4 Donaldson C, Atkinson A, Bond J, Wright K. QALYs and long-term care for elderly people in the UK: scales for assessment of quality of life. *Age Ageing* 1988;17:379-87.
- 5 World Health Organisation. *The international classification of impairments, disabilities and handicaps*. Geneva: WHO, 1980.
- 6 Ebrahim S, Barer D, Nouri F. Use of the Nottingham health profile with patients after a stroke. *J Epidemiol Community Health* 1986;40:166-9.

Rationing health care

SIR,—Contrary to Chris Heginbotham's assertion the proportion of gross domestic product spent on health care has not increased steadily in all countries of the Organisation for Economic Cooperation and Development.

Three countries (Sweden, New Zealand, and Denmark) were able to reduce the percentage of their gross domestic product spent on health care between 1980 and 1987, and two other countries (Italy and Spain) increased their spending by only 0.1 percentage units, which is less than the mean increase of 0.5 percentage units according to Heginbotham's figures (table I). Was this achieved through rationing health care or another way, such as changed accounting?

Although in 1987 the United States had the highest spending on health care in relation to its gross domestic product, between 1980 and 1987 the relative increase in spending was greater in Greece and Iceland than in the United States. If the United States and Greece are considered as statistical outliers then the spread in health care expenditure is narrow and has changed little, from 5.9 to 9.5 in 1980 to 6.0 to 9.0 in 1987. Heginbotham draws attention to the danger of relying on percentage of gross domestic product, and in his table II (where, oddly, the figures for Sweden are missing) excluding outliers the "medical care purchasing power parity" centres around \$1000. Thus, the optimal spending on health care seems to be 7-9% of gross domestic product or \$1000 medical care purchasing power in 1980's value.

The cost of caring for an individual rises greatly in the higher age groups. Short sightedly, the income tax raised in the halcyon days of the '50s and '60s when the British "never had it so good" was used to correct accumulated neglect from the years of the depression and the war; none was invested for the future. Hence, the problem facing the health service is that it has been using and still

uses current investment to defray dividends owing to past investors, which can possibly work only in an expanding economy (and is a questionable business practice). This is now being questioned.

The famous buck referred to by Heginbotham stopped with Harry Truman, not some anonymous purchaser health authority. Truman did not avoid uncomfortable decisions, even in 1948 when he fought for his political life. It is in this spirit of personal integrity and accountability that the experimental Oregon scheme should be viewed.

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1 Heginbotham C. Rationing. *BMJ* 1992;304:496-9. (22 February.)

Support for suspended surgeon

SIR,—As consultants in Dewsbury, we wish to express our support for the suspended consultant Philip Lyndon, whose case Clare Dyer reports.¹ We regard him as a capable and conscientious surgeon who has given valuable and much appreciated service to the local community. We are not aware of any good reason for his lengthy suspension and would welcome his return to work at the earliest opportunity.

Mr Lyndon's treatment casts doubt on the adequacy of safeguards in existing disciplinary procedures and suggests that a consultant's right to work is at the whim of his or her health authority. Yorkshire Regional Health Authority makes much of allegations of substandard work, but, even after the so called surgical review, Mr Lyndon was allowed to continue unrestricted practice for six months before being abruptly banned from the hospital. We know that the report on the surgical service in Dewsbury refers at some length to interviews that Mr Lyndon has given to the press. It even refers to the way he wears his operating hat, but it contains no sustainable data on morbidity or mortality at all.

JOHN SHEA, GORDON FORD, WILLIAM CASE, PETER ANGUS, EILEEN STICKLEY, JOHN THOMLINSON, VICTOR MOORE, KALY BHABRA, GILLIAN WILSON, HALEY MATHEW, ANTHONY TUCKER, ARUN GANDHI, PAUL COULDEN, OXANA MAHER, SARAH BRAYSHAW, DAVID LLOYD, ARUN MISHRA, PENNY SMITH, JOHN WETHERILL, TOM KEMP, PETER JAMES, MICHAEL LYNCH, BAS IKOKU, MALLIKA MOHANRAJ, PATRICK AHFAT, PATRICIA GUDGEON, ST CLAIR LOGAN, MARGARET EVANS, SUSAN BARNES, CHANDAN BISWAS, RANJAN KUNDU

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1 Dyer C. Surgeon accused of high mortality. *BMJ* 1992;304:733. (21 March.)

Problems of the NHS reforms

SIR,—With regard to the recent rows over the NHS in the run up to the election I wish to make several observations.

Firstly, if the government has succeeded in cutting (only some) waiting lists (for those waiting two years) before the election it is hardly surprising: regional health authorities were ordered to cut specific lists at specific hospitals, at any cost, as part of the task of implementing the patient's charter by April. This is hardly devolved management reflecting a purchaser-provider split.

Secondly, fundholding general practitioners are allocated much more money per head of population than are purchasing districts in their budgets. The grave financial consequences of this are being concealed until after the election.

Thirdly, seeking self governing trust status, like

fundholding in general practice, is increasingly popular because of the financial, managerial, and political consequences of not doing so. In many regions the approach to these matters is utterly autocratic. The constitutions of trusts, as well as Tory preference for tax cuts over social spending, make suspicion of privatisation perfectly reasonable.

Fourthly, the new system of contracts between purchasers and providers is the old system of cash limits by any other name. Providers often cannot do more to earn more money as no money is available in the purchasing budget. The patient follows the money.

Fifthly, the NHS reforms have been supported by some commentators on the dubious grounds that they allow new priorities to be set through needs assessment by health authorities. This is exactly what the government's short termism has prevented. Others who oppose the Tory reforms argue for even more radical change, such as giving health budgets to local authorities. Yet such approaches would cause huge disruption and continuing political interference.

Finally, the Labour party's health policy would actually liberate managers to address longer term priorities, with considerable devolution to provider managers yet responsibility for performance resting with local health authorities; incentives for good performance linked to longer term plans; and appropriate reimbursement to providers for patients from outside the local district. General practitioners would be given a voice in local health authorities to help determine priorities.

Partly through exhaustion from implementing the current rigmarole, managers are wary of yet more change. But this should not deflect anyone from the task of designing a more sensible health policy.

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Cold comfort for carers

SIR,—Forbes H Norris's editorial on motor neurone disease highlights the lack of interest and care shown by doctors, "including neurologists," to patients with this disorder; as the wife of someone with the disease I would say "particularly neurologists." It is therefore surprising that Tony O'Brien and colleagues find it "remarkable that at the time of referral 91 patients (73%) were being cared for in their own homes."

Most patients with motor neurone disease have no choice but to stay in their own homes: many hospices will not admit them (probably because they take so long to die), and private nursing homes can cost upwards of £400 a week, which puts them beyond the reach of most people. O'Brien and colleagues' tribute to the "courage . . . of patients and the dedication . . . of families and friends" is little comfort to people who have been left to manage as best they can.

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Isle of Wight

1 Norris FH. Motor neurone disease. *BMJ* 1992;304:459-60. (22 February.)

2 O'Brien T, Kelly M, Saunders C. Motor neurone disease: a hospice perspective. *BMJ* 1992;304:471-3. (22 February.)

Writing left handed

SIR,—As a left handed person born in 1920 and educated in England, during my schooldays I never saw a left handed child hook the hand holding the pen.¹ The reason for hooking is that

left handed children are taught by right handed teachers, who use a dogma that was created after I had left school and after ballpoint pens first became available. This dogma states that a left handed person will smear the paper unless it is tilted and unless he or she hooks the hand. This is simply not true.

When I was at school we were permitted to write only with steel nibbed pens, although fountain pens were available. If you had tried to hook your hand while using a steel nib it would have been impossible as the tip of the nib would have stabbed the paper. In my schooldays the left handed were ridiculed by teachers, and attempts were made to convert us to right handedness. When I was in medical school I joined the fencing club and had to hold the foil in my right hand as otherwise I would have an unfair advantage over my opponents. Although I rarely won a bout, at least it taught me to use my right hand.

Hebrew and Arabic are written from right to left rather than from left to right, yet right handed writers in these languages do not hook their hand.

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1 Dunea G. Left hands. *BMJ* 1992;304:579. (29 February.)

Hype from journalists and scientists

SIR,—Richard Smith may be right in general when he criticises exaggerated claims about medical advances.¹ It is, however, ingenuous to couple this with unwarranted criticism of those who are prepared to take on the necessary and sometimes difficult, and even risky, task of explaining science to the public through the media.

The human genome project is a most exciting project with extraordinary promise for improved prevention and treatment of disease. Identification of the position of genes conferring susceptibility to particular diseases, which is the most direct outcome of genome mapping and sequencing, has already led to some outstanding advances. The genes for cystic fibrosis, retinoblastoma, Duchenne muscular dystrophy, and familial polyposis have been identified, and these discoveries are already influencing medical practice and promise to do so even more in future.

It was in my capacity as president of the Human Genome Organisation that I was asked to comment on the importance of the human genome project in general and relate this to the asthma family study. My comments were therefore directed not only at the gene for asthma but at the value of the project in general, and this may not have come across in a short article. That is a risk that is always attached to communication with the media, and I make no apologies for continuing to explain the importance of this work to the public. Nothing I said could have been used to endorse a suggestion that eradicating genetic disease is easy—a term I would in any case be most hesitant to use.

"Designer drugs," as Smith describes them, are likely to be found eventually once this particular gene for asthma is discovered, as undoubtedly it will be. But even before that, giving simple prophylactic treatment with current anti-inflammatory drugs with minimal side effects to people identified as being at risk by genetic markers may well prove effective.

The public should be made aware of the excitement and promise of current medical research, including in particular analysis of the human genome. The intelligence and commonsense of patients should not be underestimated. Patients often seem to support the need for long term research to deal with their diseases more than some