knee problems referred for imaging in the two groups. In any evaluation such variations in case mix must be carefully controlled for,¹ particularly if results form the basis of recommendations for clinical practice.

It is curious that there was no orthopaedic input to the study. An orthopaedic consultant with an interest in the knee should be able to sort out most patients with knee pain on clinical grounds. Indeed, for some clinical diagnoses, such as anterior knee pain, magnetic resonance imaging has little proved clinical value.²⁻⁴ Not all general practitioners will understand the implications of the findings of magnetic resonance imaging. The sensitivity of imaging for a lateral meniscal lesion, for example, is not particularly high (approximately 0.8).^{3,4} Similarly, loose bodies may be missed. The patient may be falsely reassured and appropriate treatment delayed or denied.

From the above it might be assumed that we are not enthusiastic about magnetic resonance imaging of the knee. On the contrary, we expect the use of this type of imaging for knee and other problems to continue to increase. We are merely suggesting that widespread use is likely to lead to increased rather than decreased overall costs. When used judiciously, magnetic resonance imaging of the knee has a proved diagnostic and therapeutic impact and is associated with improvements in quality of life.⁴ We consider that patients with knee problems are best served by being seen quickly by an experienced orthopaedic surgeon, who can make appropriate referrals to a radiologist.

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1 Watura R, Lloyd DCF, Chawda S. Magnetic resonance imaging of the knee: direct access for general practitioners. *BMJ* 1995;311:1614. (16 December.)

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Paper highlights shortage of orthopaedic skill

EDITOR,—I am concerned at R Watura and colleagues' recommendation that general practitioners should have direct access to magnetic resonance imaging for knees with suspected internal derangement.¹ The basis of this suggestion was the observation that the findings on scanning for patients referred by general practitioners did not differ significantly from those for patients referred by orthopaedic teams. The claimed justification for the considerable expense involved was that patients with negative findings (26%) were not referred to orthopaedic clinics, which thus resulted in reductions in outpatient referrals and waiting lists. The authors imply that those patients referred to an orthopaedic surgeon would have required a scan anyway, but this is questionable. The authors fail to observe that the cost of a consultation with an orthopaedic surgeon with an interest in the knee is only a small fraction of the cost of a magnetic resonance imaging scan.

It can also be argued that magnetic resonance imaging scans often show spurious abnormalities, which, through doctors' lack of experience and sometimes a deficiency of clinical examination, may result in an increased number of outpatient referrals. Excessively easy access to special investigations may, at any level, be seriously detrimental to the declining art of clinical examination.

The final indications for, and the usefulness of, magnetic resonance imaging of the knee have yet to be determined by knee specialists. It is surely sensible to try to contain unnecessary costs until these are established. I suggest that this paper highlights the fact that there is a serious shortage of orthopaedic skill. Improvement in the provision of orthopaedic teaching for many present, and all future, general practitioners is needed. Much greater availability of properly trained and specialist orthopaedic surgeons is required if expensive, short sighted distractions such as direct access to magnetic resonance imaging of the knee are to be discouraged.

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Authors' reply

EDITOR,—We recommend magnetic resonance imaging for investigating suspected ligamentous or meniscal injury. In response to Jeremy Southgate and Neil Thomas, our study suggests that general practitioners are as capable as hospital doctors of requesting magnetic resonance imaging and using the results appropriately. Altogether 12% of patients with normal scans were referred to an orthopaedic surgeon and 25% of patients with cruciate meniscal tears were not referred, which indicates that general practitioners will use their clinical judgment in assessing the importance of the findings on magnetic resonance imaging. More work needs to be done to determine whether selection of patients can be improved in both groups to minimise inappropriate requests for scans. Monitoring of referrals is essential.

There are not enough consultant orthopaedic surgeons with an interest in knees to see all patients, and many patients who are referred are seen by junior staff. To employ new consultant orthopaedic surgeons with the back up of an arthroscopic theatre would have more resource implications than access for general practitioners to magnetic resonance imaging.

Mackenzie and colleagues suggest that orthopaedic surgeons may take patients direct to arthroscopy. General practitioners too may refer patients with appropriate signs and symptoms direct to an orthopaedic surgeon.

Reference is made to the skill of clinical examination by orthopaedic specialists. Unfortunately, the apparent decline in clinical skills is not just due to the availability of imaging techniques as a short cut but also because better imaging has shown the limitations of even good clinical examination.

With regard to justifying the cost of our recommendations, there are potential savings in orthopaedic referrals and value for money in improved and prompt management. A single consultation with an orthopaedic surgeon may at present be cheaper than magnetic resonance imaging, but many patients who are seen also require imaging. Having the result of imaging available at the initial consultation may save on follow up appointments.

Finally, general practitioners need to keep up to date with modern imaging, which forms an increasingly important part of patients' management. Radiologists can provide advice and guidance when appropriate.

Open access for general practitioners to such investigations as ultrasonography and endoscopy was initially opposed by hospital consultants, but few would now suggest a reversal of that policy. It would be absurd to suggest that general practitioners are capable of prescribing expensive

drugs with complex interactions and side effects but not capable of selecting patients for magnetic resonance imaging of the knee and using the results appropriately.

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Cochlear implantation is controversial among deaf people

EDITOR,—Richard Ramsden and John Graham's editorial on cochlear implantation makes it clear that, from a medical perspective, this treatment represents a great advance in the management of deafness.¹ I am surprised that the authors fail to mention the reaction that this issue has provoked among deaf people.² There is no opposition to restoring hearing to children or adults who have become deaf after learning spoken language, but in promoting cochlear implants for children who are born deaf doctors have lost the confidence of many deaf people.³

The editorial's authors point out that a deaf infant given a cochlear implant may be expected "to acquire intelligible speech" and "be educated in mainstream schools." Unfortunately, speech that is intelligible to a sympathetic listener and hearing that will never be completely normal may not be enough to enable the child to thrive in a mainstream school.

Hearing people assume that to be provided with limited speech and hearing is necessarily better than being deaf. Others have argued that the most reliable way for a deaf child to attain normal development and education is for sign language to be accepted as the child's first language. In social development, too, children with cochlear implants will fall into the group who are neither deaf nor hearing, unable to be fully integrated into a hearing world but set apart from the vibrant culture of deaf people.

There is no doubt that we live in a world that handicaps deaf people. We should not assume that the answer to this problem lies in surgery, especially when deaf people themselves are challenging such management.

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1 Ramsden R, Graham J. Cochlear implantation. *BMJ* 1995;311:1588. (16 December.)

2 Lively debate at cochlear implant forum. *British Deaf News* 1994;25(9):17.

3 BDA members discuss cochlear implants. *British Deaf News* 1994;25(10):6.

BMA division disagrees with association's stance over advance directives

EDITOR,—Bromley division of the BMA is seriously concerned by the association's stance over advance directives. The BMA originally expressed the view that "mutual respect and common accord is better achieved without legislation" and stated that "the BMA does not support legally binding advance directives." Despite this and the decision of the annual representative meeting in 1993 that "in the matter of advance directives, no doctor should be obliged by patients, relatives or hospital admini-

strative staff to act contrary to his conscience," the association has failed to uphold the clear view of the profession. We understand that this is because it has been persuaded by members of the legal profession that expressions of advance wishes would be upheld at law. This, however, has not been tested in practice and is not accepted by some lawyers. In any case, advance directives should have been opposed as being incompatible with good medical practice and ethics rather than accepted as a fait accompli.

At the annual representative meeting it was inappropriate, especially for a matter of such grave importance, to conflate six motions expressing concern or even criticism of advance directives with two motions in favour of them so as to make a single, unwieldy motion (motion 470). Since a motion had just been passed to the effect that the matter had been inadequately discussed in the profession (469), and in view of the number of motions originally submitted and the number of would-be speakers, it is regrettable that no time was then found to debate motion 470 at all.

Bromley division believes that the following are important dangers of advance directives: developments in treatment cannot be accommodated; advance directives may prevent resuscitation in an emergency (this has happened) or even assessment over time to see whether the situation is reversible; survival after "non-treatment" may lead to a worse state than would have been the case if proper resuscitative measures had been carried out; doctors' hands are tied by a document that may require them to act contrary to informed medical opinion (and their consciences); and doctors and nurses, and their skills, effectively become redundant in such situations.

Medical staff tend to avoid those who spurn their best endeavours, and patients' care will suffer in consequence.

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Doctors and medical politics

Electorate should be balloted on measures profoundly affecting clinical practice

EDITOR,—The whingeing doctors of whom Douglas Carnall writes may stand on the sideline of medical politics,¹ but they work in the front line of clinical practice, where the BMA and its various committees often seem a long way away. The actions of our political leaders become of real interest only when they result in that line being moved. We are, after all, registered as doctors and not politicians.

The letter criticising the new deal that Carnall cites (of which we were two of the signatories) was born out of feelings of frustration and impotence.² We accept that we and our coauthors may be guilty of the apathy that Carnall identifies with regard to elections to the BMA's council. In this matter, however, we are a single issue, minority group. Given the figures that Carnall provides, we could possibly secure representation on the council, but would this be good for the profession as a whole? It might be better to reduce the number of constituencies, so that those people who are genuinely interested have to compete for their posts, and to make it incumbent on them to ballot the electorate on measures, such as the new deal, that profoundly affect clinical practice. Any such ballot must take into account the heterogeneity of clinical medicine and identify the opinions of different groups within this. Our political leaders would then be equipped to represent not only the profession as a whole but also its various component parts. We would be happy to feel that we could devote our time and energy to our

vocation rather than whining and whingeing in the letters pages of the *BMJ*.

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- 1 Carnall D. Doctors and medical politics. *BMJ* 1995;311: 1519-20. (9 December.)
- 2 Alhulafi A and 64 others. New deal not satisfactory for cardiothoracic surgery. *BMJ* 1995;311:953. (7 October.)

BMA is meeting change with outraged reaction rather than adaptation

EDITOR,—Hooray for editorial registrars! Douglas Carnall has bravely tackled the fundamental problems facing representative organisations such as the BMA.¹ The association has recruited and accredited a new nationwide echelon of local medical politicians numbering roughly 4000, but the development of local negotiating committees may become a lost opportunity. Despite excellent work by officials in setting up and training local negotiators in industrial relations, media presentation, and negotiating skills, the central response to innovative local agreements has been derision, suppression, or attempted sabotage. Local negotiating committees are close to the members and their views but substantially remain outside the policymaking of their association, like judges making case law separate from statutory laws.

The association has yet to learn the difference between central control and local negotiation and remains ambivalent about the balance between local and central policymaking. There is indeed dissatisfaction among members with the representativeness of central craft committees and the realism of their edicts. Alas, the association is typically meeting the changed environment with outraged reaction rather than biological adaptation.

Despite the success of local medical politics, few local people will be inspired to seek national roles or would seem to be welcome if they did. The 15th century Venetian intrigues may be the very being of lifelong activists, but ordinary doctors can better find influential roles by entering the management of trusts locally than by getting on the 7 am train to London.

The BMA must reform itself to bring itself into the 20th century if it is to reach the 21st. We have a secretariat of great erudition and capability, local officials of immense practical skill and experience, and many new local politicians, yet we lie enchained by the shackles of Victorian organisational and representational architecture. A managerial revolution is afoot. We must also bring more active members into creative policymaking teams and do away with the annual coconut shy.

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- 1 Carnall D. Doctors and medical politics. *BMJ* 1995;311: 1519-20. (9 December.)

Long term care can be provided by NHS at low cost

EDITOR,—John Warden draws attention to the increasingly difficult problem of caring for elderly patients who need high dependency nursing care but not expensive hospital beds.¹ One way in which good nursing home care can be provided at relatively low cost is by enlisting the voluntary sector. Experience in the Wirral shows that this

can be achieved. The staff of the department of medicine for the elderly at Clatterbridge Hospital, headed by Dr John Aitken, thought of establishing an independent, non-profit making nursing home on the hospital campus to relieve pressure on hospital beds; active support came from the NHS at local and departmental levels, and the home opened in November 1989.

The hospital authority built a nursing home with 49 individual rooms and leased it to a limited liability company with charitable status created for the purpose. Management was vested in a board of unpaid directors (local people actively interested in the care of elderly people, with wide experience in medical and other fields). It took some time to establish a competent management structure, which comprises a matron, an administrator, and a financial assistant. This made the home virtually able to run itself, with only policy decisions and advice in emergencies being required from the directors. This has worked well. The directors visit the home informally and develop areas of special interest in its affairs. A formal board meeting is held each month.

The objective has been to provide care for patients with low incomes on the basis of the support available from social services (currently £295 a week). We have shown that with careful budgeting an excellent service can be provided on this income alone. It is, however, vital for a home run on this basis to be as fully occupied as possible. Difficulties are that the local social services cannot fund all eligible patients and have, indeed, asked homes whether they can accept lower fees. Present information suggests that locally about 80 potential nursing home patients remain in hospital beds.

Our experience shows, firstly, that a useful element in solving the problem of long term care is to mobilise local interest and talent in the manner described; and, secondly, that the financing of such a scheme is imperilled if money from social services dries up, as is threatened in our case. The care of elderly patients needing nursing rather than hospital care would be facilitated if financed by the NHS rather than social services.

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- 1 Warden J. Long term care pushed on to NHS. *BMJ* 1995;311: 1454. (2 December.)

Policies for humanitarian service should be less ageist

EDITOR,—Peter Beale writes that colleges and trusts should show greater understanding towards medical staff who wish to do humanitarian work.¹ I have just returned from Kurdistan in north Iraq, where I spent six weeks helping Emergency, an international organisation based in Milan, to set up and open a 50 bed surgical centre. When I retired from full time anaesthetic practice at the age of 63 I offered my services to the British Red Cross Society but was turned down as I was too old. I understand that other Red Cross societies do not have this age limit and that older doctors work with the International Committee of the Red Cross, but access to the international committee is through the national societies.

While in Kurdistan I celebrated my 74th birthday. I suggest that the British Red Cross Society should adopt a less ageist policy.

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- 1 Beale P. Colleges and trusts are blocking humanitarian service. *BMJ* 1995;311:1027. (14 October.)