proportion of patients requiring high dependency and intensive care. To accommodate the additional emergency caseload we have returned about one third of elective cases, scheduled for high dependency care on the unit, direct to the ward. This has put additional strain on the ward staff. Cancellations of elective surgery requiring postoperative intensive care have unavoidably increased.

Our experience highlights the underprovision of intensive care beds in the south east of England. We welcome the recent announcement by the secretary of state for health of increased provision of intensive care services,³ but in the neurosciences we think that it may be too little too late.

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1 Halle M. Finding fails to find bed search. *Hospital Doctor* 1996 Mar 21:32-3.

2 Society of British Neurological Surgeons. *Safe neurosurgery*. London: SBNS, 1993.

3 Carnall D. UK reviews intensive care and emergency services. *BMJ* 1996;312:655. (16 March.)

Severe problems with interhospital transfer of critically ill children will continue

EDITOR,—Like many others involved with interhospital transfer of critically ill children, we find that it is extremely difficult. We have much sympathy with the predicament of Dr Ruth Jameson and her team during the transfer of Nicholas Geldard on the night of 2 December 1995.¹ It has been suggested that, once Nicholas was found to be dead at Hope Hospital (although formal tests to confirm brain stem death had not been done), a bed should have been found for him nearby. It is further suggested that the transfer to Leeds should have been cancelled. This is the nub of the criticism of Dr Jameson's team in the report on the case by North West Regional Health Authority.²

Our unit was the nearest paediatric intensive care unit and was full on the night that Nicholas died. We do not provide ventilatory support on wards other than the intensive care unit. This practice was instituted many years ago after an audit of ventilatory support on general wards at our hospital showed that the results were bad. We have also prospectively audited critical incidents among patients coming into our unit, of which there are a depressingly high number.³

It is extremely difficult to effect a major change in the direction of treatment during interhospital transfer. The report does not explain how Dr Jameson was expected to effect this when a local paediatric intensive care bed was not available, although paragraph 143 of the report is critical that this was not done—a criticism that we regard as unjustified. The people who criticise should try transferring a few sick children before they speak again. Those who have experience of interhospital transfer are well aware of the difficulties that can arise.

The counsel of perfection is to have a paediatric emergency transfer service and sufficient intensive care cots. Until that time, doctors transferring patients can expect to encounter severe problems during transfer and unjustified criticism after it.

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1 Carnall D. UK reviews intensive care and emergency services. *BMJ* 1996;312:655. (16 March.)

2 North West Regional Health Authority. *Inquiry into the care and treatment of Nicholas Geldard*. Liverpool: NWRHA, 1996.

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Surgeons will not want jobs in hospitals that do not do emergency surgery

EDITOR,—Proposals to rationalise the delivery of accident and emergency, trauma, and emergency surgery have a good clinical basis and are a response to the pressures of junior staffing, hours of work, and cost effective care. Many advantages accrue to patients, staff, and the delivery of services when a hospital's routine does not have to accommodate emergency surgery. Patients sleep better, and theatre lists can be planned with confidence.

When these proposals become a reality, there are several unexpected byproducts. The loss of acute trauma and emergency surgery from a hospital changes its character. Minor accident and emergency services and elective surgery become the norm, and the physicians may be reluctant to admit medical emergencies without surgical cover. The Royal College of Surgeons withdraws the hospital's recognition for training junior staff. Surgeons deprived of emergency surgery, if still chasing the "bubble reputation," decamp to hospitals that satisfy their aspirations. Their replacement is the problem. Surgical posts that exclusively provide elective surgery are unlikely to attract accredited senior registrars who aspire to practise the full range of the discipline. Consultants in the later stages of their career, surgeons from overseas, or some of the numerous surgeons based in Britain who have been unsuccessful in achieving a substantive consultant appointment are likely to apply. The main problem facing the trusts is the attitude of the college assessor, who may stick rigidly to the view of "no accreditation, no job." This then places the trust in the position of making an appointment that may conflict with the assessor's recommendation—an unsatisfactory but necessary decision so that surgical services can be provided for the population.

Those planning the centralisation and rationalisation of services need to consider how surgical services can continue to be provided in those hospitals deprived of emergency surgery. It is also necessary to be aware of the political consequences that result when a local population and politicians are convinced that rationalisation is about cutting services to which they are accustomed.

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Television and radio should be used to disseminate important information

EDITOR,—Since the Committee on Safety of Medicines' statement about the safety of third generation oral contraceptives¹ concerns have been expressed about how information was disseminated during the "pill scare." Sally Hope is concerned about how similar messages might be handled in future.²

The National Coordinating Unit for Clinical Audit in Family Planning has looked at the recent dissemination of information warning of the risks associated with oral contraceptives. In initial reports, family planning professionals complained that they received information from the media before seeing the official statement from the Committee on Safety of Medicines, which caused some confusion, anxiety, and misinformation. In

Table 1—Initial and subsequent sources of information about recent pill scare reported by 234 family planning professionals

	Initial	Subsequent
Public media:		
Television, radio	111	156
Newspapers, magazines	9	160
Orally from colleague	49	127
Committee on Safety of Medicines' letter	21	181
Orally from patient	18	71
Letter from Faculty of Family Planning and Family Planning Association	4	187
Pharmaceutical company	4	170
Email	1	19
World Health Organisation's statement	0	39
Other	17	23

December 1995 the unit circulated a questionnaire to regional advisers of the Faculty of Family Planning and delegates who attended the national audit conference. Of the 242 respondents who returned their questionnaire by 18 January, 103 were general practitioners, 60 family planning doctors, 59 family planning nurses, 12 practice nurses, and 7 "other."

The Committee on Safety of Medicines' statement preceded other sources of information in only 9% of cases (table 1). Over half of the respondents obtained their initial information from the media, a fifth received it orally from a colleague, and 8% heard the information first from their patients. The number of official sources from which the respondents had heard differed, with 34 respondents receiving only the committee's letter, 40 only the letter from the Faculty of Family Planning and Family Planning Association, and 147 both letters; 21 were still waiting for either.

With any urgent statement concerning medical practice it is important that experts act as the primary sources of information to clinicians so that patients can receive correct information. Acting as the primary distributor is difficult: family planning is provided by a wide range of specialists, including general practitioners, community nurses, family planning doctors and nurses, gynaecologists, and midwives. There is the added challenge of contacting other medical colleagues for whom contraceptive problems may not be a major focus of clinical services. Thus a variety of methods for disseminating information will probably be necessary. If the public media of television and radio result in the most rapid dissemination of information, as our survey indicates, then they should be consciously used to disseminate official statements, with rapid follow up of written information sent by more than one route.

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1 Committee on Safety of Medicines. *Combined oral contraceptives and thromboembolism*. London: CSM, 1995.

2 Hope S. Third generation oral contraceptives. *BMJ* 1996;312:576. (2 March.)

Gynaecological problems should continue to be treated in primary care initially

EDITOR,—S K Smith's provocative editorial argues that a more medical approach is needed in gynaecology.¹ We are general practitioners in a