I would not perform a major operation in a private hospital that was not set up to deal with the complications. Treating private patients in the NHS base brings money into the trust.

I believe that the NHS provides a good service. The reasons for paying a private subscription, however, are many and include being able to see a consultant of your choice (this is more difficult in the NHS since the advent of extracontractual referrals); to have your consultations and be treated promptly and conveniently and in pleasant surroundings (this does not happen in most NHS settings); to enjoy privacy (ditto); and to have a wide choice of edible food (ditto).

If Currie would not allow his family to be treated anywhere other than in his own NHS hospital then the local private hospitals must indeed be in a sorry state, or perhaps he has not visited them recently. It is a shame that Currie has resigned from membership of the BMA at a time when great changes are occurring in his NHS and when the BMA surely needs all the support that it can get.

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1 Currie D. BUPA subscription? That will do nicely. *BMJ* 1996;313:431. (17 August.)

Insurers, doctors, and patients do not need to be apologetic about private treatment

EDITOR,—The private sector facilities that David Currie describes in his area bear no resemblance to those of the clinics in which I work.¹ The days when private treatment was restricted to minor surgery in "dubious nursing homes" are long past, and the private sector, at least in the south east of Britain, has expanded to cover almost every medical and surgical contingency. In some private clinics facilities are now provided that match and sometimes surpass those in the best NHS units. Of course there are good and bad units—and probably good and bad doctors—in both public and private sectors, and so, unlike Currie, I find it entirely understandable that some people wish to choose for themselves what they consider to be the best available care.

Although most doctors in Britain are committed to the NHS, many can appreciate the advantages of having a private sector in parallel with public facilities. I do not believe that the medical insurers, doctors, or, indeed, patients need be in the least bit apologetic about choosing to operate or be treated outside the NHS. With the advent of audit and accreditation it will not be long before private practice can be conducted only in properly accredited units, and I find it interesting that most hospitals already accredited by the King's Fund are in the independent sector.

Currie's article, in which he refers to his "brooding", "resentment", "enragement", and "spiteful satisfaction," amply testifies to his bigoted perspective; fortunately, both readers and the general public have the freedom to choose whether to be influenced by him. Most, when inquiring about the benefits of private health care, will seek accurate and unbiased information before committing themselves to an opinion, a decision, or, indeed, a subscription.

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*Of the nine other letters that we received on this subject, three supported private practice while the remaining six agreed with David Currie's views.—EDITOR

Jury is still out on National Blood Service

EDITOR,—E Angela E Robinson criticises Ann Oakley's editorial about blood donation for being based on a catalogue of false premises.^{1,2} The rosy picture of the English blood transfusion service that Robinson paints, however, does not match my experience. Staff morale, an indicator of the wellbeing of any organisation, is at an all time low as the proposals to rationalise the service are forced through. The departure of so many skilled and experienced staff is also a matter of considerable concern to users of the service.

Though Robinson rightly thanks donors for their ever increasing number of donations, she claims that the volume of blood collected is determined by hospitals' needs. While this may be broadly true, too many serious shortages of blood have occurred. For example, during 1995 stocks of O negative red cell units fell below the National Blood Authority's own minimum target on 31% of occasions. Conversely, stocks of group AB red cell units have averaged 11% of the total national blood stock, although only 3–4% of patients can receive AB blood. These deficiencies are not indicative of a well managed organisation.

While an increasing number of countries use tests for antibodies to hepatitis B core antigen and to human T leukaemia/lymphoma virus types I and II, the English blood transfusion service believes that the introduction of these tests is not yet justified. Yet Robinson claims that the National Blood Service is recognised as the finest and safest in the world. On the very day that Robinson's letter was published the popular press reported the withdrawal of batches of factor VIII and human albumin solution because of possible contamination of source plasma with hepatitis C virus; this underlines her own false premise.

An unprecedented number of donors complained that surplus products had been sold without their expressed informed consent. Robinson should therefore heed Oakley's advice about the need for donors to have a greater voice in the use of their blood. This is especially relevant given the changing nature of the blood service, which is no longer supervised by local clinical directors but is increasingly managed by remote businessmen.

While the old National Blood Transfusion Service may have been among the finest and the safest in the world, the jury is still out regarding the new service controlled by the National Blood Authority.

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1 Robinson EAE. Blood donation. *BMJ* 1996;313:428. (17 August.)

2 Oakley A. Blood donation—altruism or profit? *BMJ* 1996;312:1114. (4 May.)

Caring for older people

Caring for carers should be included in undergraduate curriculum

EDITOR,—In her article on carers who care for older people Anne F Travers states that carers need recognition, information, and support from the health professionals with whom they are in contact.¹ A recent Gallup survey, however, showed that 45% of carers receive no help whatsoever in their caring role.² Since there are an estimated six million carers in Britain, this represents an enormous number of carers not receiving recognition, information, and support. Travers's article offers suggestions that could be implemented in both primary and secondary

care to improve support for carers, but I believe that medicine should be proactive at a much earlier stage, with specific teaching on carers, their needs, and sources of support being provided at undergraduate level.

The General Medical Council has recently highlighted the importance posed by chronic illness and disability in an increasingly elderly and disabled population and the fact that all clinicians, regardless of their specialty, should have insight and experience of such care. Despite the council's latest recommendation that teaching on chronic illness and rehabilitation should be included in the core undergraduate medical curriculum,² the amount and content of such teaching in British medical schools is generally inadequate.^{3,4} The new undergraduate curriculum at Newcastle upon Tyne includes a four week rotation, "chronic illness and rehabilitation," which is mandatory. A session on caring for carers focuses on identifying carers and their needs and providing information and support. I would be interested to know how many (or, I suspect, how few) other medical schools provide such formal teaching.

In patients' and carers' opinions, doctors, especially general practitioners, still have a pivotal role in providing patients with advice and information,⁵ but does current undergraduate and postgraduate medical education adequately equip our doctors with the skills to support carers? The introduction of the Carers (Recognition and Services) Act 1995 will make assessment of carers by local authorities mandatory. Teaching medical students and junior doctors to identify, listen to, and take care of carers should follow a similar course.

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1 Travers AF. Caring for older people: carers. *BMJ* 1996;313:482–6. (24 August.)

2 General Medical Council. *Tomorrow's doctors. Recommendations on undergraduate medical education.* London: GMC, 1993.

3 Marshall J, Haines A. Survey of the teaching of disability and rehabilitation to medical undergraduates: the UK. *Med Educ* 1990;24:528–30.

4 Kattan S, Inman C, Haines A, Holland P. Teaching disability and rehabilitation to medical students. *Med Educ* 1994;25:386–93.

5 Chesson RA, Sutherland A. General practice and the provision of information and services for physically disabled people aged 16 to 65 years. *Br J Gen Pract* 1992;42:473–6.

Carers need financial assistance to buy help

EDITOR,—Having personal experience of being a long term carer and having seen some of my friends struggle to fulfil this role, I have become convinced that, while the endeavours of organisations for carers¹ are to be respected, the only important thing that makes a difference is practical financial help.

The most effective way of ensuring that long term caring does not become a depressing and never ending burden and chore is to find other people to do it for you. However hard people try to tell you that it is a labour of love, sooner or later—if you are having to do everything for the person for whom you care—resentment and anger begin to take over. No amount of recognition, information, and moral support can substitute for a professionally trained person doing the daily work involved in looking after an incapacitated person. Professional carers can go home at the end of the day. Amateur carers are stuck with their duties day and night for seven days a week.

Putting this burden on families is a cheap and nasty way of solving a difficult problem. Support groups, counselling, or a sympathetic ear do not ease the trauma of constantly changing the bed of a doubly incontinent parent, of having to feed

three times a day a relative who is totally incapacitated by a stroke, or of being in constant contact with a person whose mind has long gone. What carers need is financial assistance to buy the help they need to retain their sanity and to provide them with a reasonable quality of life.

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1 Travers AF. Caring for older people: carers. *BMJ* 1996;313:482-6. (24 August.)

Article omitted to mention Princess Royal Trust for Carers ...

EDITOR,—Anne F Travers's article on carers who care for older people contains much needed advice to doctors to help them recognise the special needs of carers.¹ But in referring to relevant organisations it does not mention a national organisation dedicated to giving a range of practical help to carers—namely, the Princess Royal Trust for Carers.

The Princess Royal Trust for Carers has established 50 centres for carers across the United Kingdom since it was set up five years ago. Each centre provides three core services: information and advice on every relevant issue, including benefits, respite care, support services, and aids and adaptation; emotional support; and community consultation, enabling carers to influence local policy on community care. As each centre develops it may also provide advocacy, group support, practical help, relief care, education, and the opportunity for carers to enjoy a social life. Carers are given support before they reach breaking point, and the focus is very definitely on their needs.

All too often we hear that the first time that carers come to the attention of their general practitioner in their own right is because they have broken down under the strain of their caring responsibilities. This frequently leads to emergency admission to hospital for the person who is being cared for as well as treatment for the carer.

As Travers points out, many carers would not recognise themselves by that name. Thus referrals from general practitioners and other health professionals are essential if the Princess Royal Trust for Carers is to provide the support that carers need in ways that they want to a consistently high quality.

Each of the trust's centres for carers is partially funded through voluntary donations from individuals, companies, or trusts that give grants in partnership with the local authority. The Princess Royal Trust for Carers aims to establish a centre for carers in each local authority area, and many are already working in partnership with hospitals and general practices. Anybody who would like details of their nearest centre should telephone the trust (0171 480 7788 or, in Scotland, 0141 221 5066).

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1 Travers AF. Caring for older people: carers. *BMJ* 1996;313:482-6. (24 August.)

... and Crossroads Association

EDITOR,—I was disappointed that Anne F Travers's article on caring for people who care for older people makes no mention of the main voluntary organisation providing support for carers and those whom they look after.¹ The Crossroads Association was set up in the early 1970s to provide a focus for the needs of carers

and now has branches throughout England, Wales, and Northern Ireland, while its partner organisation, Crossroads (Scotland), provides services in Scotland. Branches provide care attendant services for disabled people and their carers of all age groups, and Crossroads has taken the lead in developing both research and services for younger carers. Over 25 000 families use Crossroads, with over two million care hours being provided each year.

Travers's article states that carers need three things from their doctor (recognition, information, and support), to which I would add a fourth—namely, education. Information alone is rarely adequate, and often very simple education programmes in primary care may make the task of caring and the risk of breakdown, and therefore institutionalisation, much less.

We would be pleased to receive comments about people's experience of or inability to obtain holidays, which may be difficult because of difficulties at home or because of the lack of facilities available to disabled people.

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1 Travers AF. Caring for older people: carers. *BMJ* 1996;313:482-6. (24 August.)

Infants in Sandwell are screened for haemoglobinopathy gene

EDITOR,—Linda Laird and colleagues are right in stating that it is important to cater for the needs of families with infants who are found to be carriers of a haemoglobinopathy gene.¹ We believe that families should be fully informed when a screening programme detects a heterozygous carrier infant.

Since 1992 we have run a selective newborn screening programme in Sandwell (population 295 000; a quarter of births are to couples in which one or both partners are from an at risk group). We have an explicit screening protocol. The haemoglobinopathy services committee oversees the programme and arranges training for all staff.

Because we obtain consent before the screening test is done, we believe that we should also feed the results back. The health visitor receives a copy of the result of every test. She discusses the haemoglobinopathy trait status at the 6 week check as part of routine child care. All infants receive a laminated national haemoglobinopathy card showing their haemoglobin type. The general practitioner is also sent a copy of the result for the infant's record. The consultant haematologist and specialist nurse confirm the result at 6 months, counsel the family, and

undertake cascade screening if necessary. In the four years to 1995 we screened 4611 infants, of whom 3.17% were found to have an abnormality (table 1).

Our experience shows that it is possible, at a district level, to provide a sensitive screening service with full regard for the needs of families with infants with haemoglobinopathy trait. Such responsiveness to local community groups may not be possible with large multidistrict or regional screening programmes,² which focus largely on detecting infants with disease states.

In setting up our service we did not see the detection of carriers as an "inadvertent consequence" of screening. Instead, such detection was always one of the benefits that the community wanted: knowledge about their genetic make up. We also believe that health visitors are a considerable resource: with training and support they can take on the bulk of the work involved in giving information about test results to families in community genetic screening programmes. Sandwell's experience shows the benefits of collaboration among clinicians, community groups, and public health physicians.

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- 1 Laird L, Dezateux C, Anionwu EN. Neonatal screening for sickle cell disorders: what about the carrier infants? *BMJ* 1996;313:407-11. (17 August.)
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Proportion of *BMJ*'s editorials on medical subjects is decreasing

EDITOR,—Clinicians regard medical journals as a vital source of their continuing medical education.^{1 2} The *BMJ* particularly is regarded as important reading for both general practitioners and hospital specialists looking to maintain a broad base of up to date medical knowledge. We audited the editorials in the *BMJ* to establish whether the subjects that they covered had changed over the previous 35 years.

We reviewed all the editorials contained in the first four months' issues of the *BMJ* at five year intervals from 1958 to 1993. The subject of each editorial was classified as medical (clearly an area of medicine), administration and politics (changes in the health service, fundholding, etc), or other (topics not suitable for the other categories). The classification, based on the title of the editorial and a detailed scan of the text, was performed initially by JMG. A sample of the editorials was then reviewed independently by AKN and AG; on cross checking, the same classification was found to have been allocated to 95% of the editorials.

Altogether we reviewed 883 editorials, giving a mean of 110.37 per four month study period (range 76-132). There were 96 editorials per four months in 1993 and 1988, 76 in 1983, and over 100 between 1958 and 1978. The number of editorials about administration ranged from 16 in 1983 to 37 most recently; the proportion rose from 15% (17/113) in 1978 to 39% (37/96) in 1993, the

Table 1—Number of cases of each haemoglobin type found on neonatal screening in Sandwell

Haemoglobin type	No (n = 4611)
Normal (AA)	4463
Abnormal	148
Carrier states:	
AS	78
AC	33
AD	17
AE	15
AG	2
AJ	1
Disease states:	
SS	1
SC	1