spoke in support of their experiences of the scheme.

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1 Edwards A. Women consultants. *BMJ* 1994;308:1303. (14 May.)

New start dates for medical posts

EDITOR,—P D Miller gives an inaccurate account of the introduction of compulsory induction courses and the new starting day for hospital medical and dental staff.¹ The new procedures were first discussed with the profession well over a year ago and were announced on 4 January this year as guidance, not as a directive. Further guidance was issued in April to clarify certain operational queries. As before, the wording of this supplementary guidance had been submitted to the BMA and the Junior Doctors Committee for consultation and comment before it was issued.

The Junior Doctors Committee responded in writing and confirmed that, although it remained convinced that Monday was the preferred option for its members, it did not object to the specific issues covered and was happy for the guidance to be circulated as soon as possible. The BMA replied in similar vein. At the most recent meeting of the joint negotiating committee (junior) on 28 April, a few days after the guidance was issued, the representatives of the Junior Doctors Committee raised a few further queries but did not request that the guidance should be withdrawn.

There is no question of house officers not being paid for their day of induction, and the guidance states that existing successful induction courses that have local educational approval need not be prejudiced.

Medical staffing departments are responsible for ensuring that the service is adequately staffed. New preregistration house officers will join their hospitals a day before they start ward duties, and existing preregistration house officers have been asked to remain in their posts for a further two days this year to allow this change to be implemented. Similarly, senior house officers will start their new jobs on the first Wednesday; no hospital should therefore "have two sets of . . . senior house officers while other units have none" unless present postholders choose to leave their posts on 31 July.

I do not accept that this change will not improve patient care; it is long overdue. Despite some local problems associated with its introduction, most of which would have occurred whenever it took place, most comment from the service has been welcoming. Most new doctors will also welcome the opportunity to take part in properly structured induction courses uninterrupted by the pressures of the bleep. The benefits to patients resulting from doctors being confident and oriented are obvious.

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1 Miller PD. New start dates for medical posts. *BMJ* 1994;308:1442. (28 May.)

Profession's ideas are ignored

EDITOR,—In his interview with England's chief medical officer Richard Smith raised the question of why the profession was so slow in coming forward with its own ideas.¹ In response Dr Calman referred to a document from the National

Association of Health Authorities and Trusts and wondered why it had not come from general practice. I wish to point out that almost every recommendation in the document came from the profession and was either implemented or in the process of implementation. For instance, on the question of objective assessment, which seems to be the main battle cry of the National Association of Health Authorities and Trusts, a perusal of the literature would have shown that formative assessment has been an integral part of training in general practice for many years and became mandatory from January 1993. Summative assessment has also been the subject of much debate, and this year most regions have introduced it on an experimental basis with a view to its mandatory introduction from 1996.⁴

As far as the recent changes in the NHS are concerned, the service needs have already had considerable impact on the curriculum in vocational training. For instance, participation in audit and learning about management skills and the effectiveness of health care now feature highly in our training programmes. Furthermore, with respect to continuing medical education, personal educational plans have become an accepted form of accredited activities; in Yorkshire alone we have had some 80 completed plans since 1989.⁵ There has also been a lively debate based on the document produced by the General Medical Services Committee's task force on specialist reaccréditation. I have no doubt that, given time and adequate resources, reaccréditation will eventually be introduced.

Thus, the real question that needs to be addressed is why a document produced by the National Association of Health Authorities and Trusts receives such huge publicity whereas the many splendid ideas of the profession, on which the document was based, are often ignored.

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Training in anaesthesia and other specialties

EDITOR,—One of the main sources of anxiety among doctors in training is being faced with a patient presenting with an emergency for which the trainee feels insufficiently trained. We believe that the principles that are used to train anaesthetists would be advantageous to trainees in other specialties in which emergencies are a feature.

In paediatrics and general medicine in which we trained to registrar level, we gleaned the principles of managing patients as an emergency largely from our immediate superiors in the course of their busy day and through being "thrown in at the deep end." During our first month as senior house officers we were supposed to be covered by registrars at all emergencies, who were often busy and even on different sites. This meant that they often arrived late, adding to the stress of the clinical situation. Consequently, we were frequently unsupervised and teaching techniques were inconsistent.

In anaesthesia a period of supernumerary training is necessary to enable anaesthetists to perform at even the most basic level. We remained surplus

to service commitments for three months. This entire period was spent attached to the two senior consultants in the department who train novice anaesthetists. During this time we were tirelessly criticised and corrected over mistakes that we made and each situation to which we did not respond rapidly or appropriately. Though on occasions stressed and despondent, we certainly considered afterwards that we had learnt to administer basic anaesthesia and could carry out resuscitation procedures confidently and competently.

The report of the Working Group on Specialist Medical Training recommends the introduction of improved training programmes by the end of 1995 and that the medical royal colleges and their faculties should specify the curricular requirements for planned specialist training programmes no later than this month.¹ We think that formal training in the management of common emergencies would improve the quality of medical training and that it should be provided for all new trainees starting in medical specialties in which emergencies regularly feature. Having trained in medicine and anaesthesia, we believe that a short supernumerary introductory training programme, aimed at encouraging rapid, systematic responses to everyday medical emergencies, would have prepared us better to cope with the emergencies we faced at the start of our medical posts.

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1 Department of Health. *Hospital doctors: training for the future. The report of the working group on specialist medical training*. London: DoH, 1993.

Community hospitals in the new NHS

EDITOR,—Doctors working in community hospitals will have been disappointed by the lukewarm tone of Sam Ramaiah's editorial.¹ This tone is surprising at a time when interest in the concept of community hospitals has increased greatly, with new hospitals being built (or converted from other types of hospital) in many areas. In Scotland alone, new units have opened in Grampian and Highland and are being planned in Ayrshire and Arran and even in the City of Aberdeen.

Ramaiah seems to see these as long stay units in competition with private nursing homes. Certainly there are long stay beds in community hospitals, as in other NHS hospitals, and urgent debate is needed on the role of the NHS in the provision of long stay care. Community hospitals (or, more accurately, general practitioner-community hospitals) are not, however, primarily long stay institutions. In an audit of admissions to 11 Scottish general practitioner community hospitals in 1989-90 the Scottish Association of GP Community Hospitals found 69.3% to be for acute medical conditions, 11.9% for respite care, 9.9% for convalescent care, and 8.9% for terminal care (unpublished data). Seventy per cent of patients were discharged home, and only 4% went on to require long stay care. The average length of stay was 15.4 days, with 18.4 discharges per acute bed and an occupancy rate of 75%.

If care in the community is to work well, and if the expected increase in the number of extremely elderly patients is to be coped with by primary care, then the presence of community hospitals as a safety net when acute illness intervenes is going to be even more important than it is now. If Ramaiah has failed to understand the important acute role of general practitioner-community hospitals it may be because we who work in these hospitals have

failed to communicate our role to the rest of the profession.

Unfortunately, however, Ramaiah also fails to understand the role of the purchaser-provider split and general practice fundholding in relation to community hospitals. At the moment (apart from surgical care in a minority of hospitals) none of the inpatient care in general practitioner-community hospitals is purchased by general practice fundholders. If the fundholding scheme develops further, to include all inpatient care, general practitioners will have the chance to use their purchasing power to develop the facilities available at their own general practitioner-community hospitals and will certainly wish to use these hospitals, when clinically indicated, in preference to the private sector or district general hospitals. My private discussions with many fundholders lead me to believe that a powerful motive for becoming a fundholder is the hope that the scheme may allow general practitioners to develop diagnostic, therapeutic, and outpatient facilities at their local general practitioner-community hospitals. Far from being seen as a threat, the new NHS, and in particular general practice fundholding, could prove to be a great opportunity for general practitioner-community hospitals.

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1 Ramaiah S. Community hospitals in the new NHS. *BMJ* 1994;308:487-8. (19 February.)

Pre-hospital deaths from accidental injury

EDITOR,—In their article assessing the preventability of deaths from injuries, L M Hussain and A D Redmond present convincing evidence that some accident victims are dying because of ignorance about basic airway management at the scene.¹ However, their assessment that death was preventable in at least 39% of those who died from accidental injury before they reached hospital is tenuous.

Their assessment is based principally on the fact that 46 of 152 patients who died before reaching hospital had an estimated survival probability greater than 50%. The probability estimates for the survival of these patients were based not only on calculations on data that are over 30 years old, as the authors state, but also on Bull's data, which were collected only for deaths in hospital.² Bull explicitly excluded pre-hospital deaths from his calculations. Even allowing for the likelihood that survival probabilities are higher now than 30 years ago when the data were collected, it is difficult to see how "Bull's probits" relating age and injury severity score to the chance of survival after reaching hospital alive in 1961 relate to the chance of surviving until reaching hospital in 1987-90.

The authors also claim that, excluding inevitable deaths in patients with injury severity scores of 75, those who died before reaching hospital were not more seriously injured than those who died in hospital. This is not true ($\chi^2=16.2$, $P=0.005$).

In trauma research the practice of using "norms" or "standards," whether from England 30 years ago or, more commonly, from America 10 years ago, is widespread. Although these norms may provide a useful tool for audit, they cannot be used in research for measuring effectiveness.

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1 Hussain LM, Redmond AD. Are pre-hospital deaths from accidental injury preventable? *BMJ* 1994;308:1077-80. (23 April.)

2 Bull JP. The injury severity score of road traffic casualties in relation to mortality, time of death, hospital treatment time and disability. *Accid Anal Prev* 1975;7:249-55.

Author's reply

EDITOR,—I share Jon Nicholl's (and others') criticisms of mathematical models for predicting outcome from injury. Nevertheless, there is no truly objective alternative, although groups across Britain are working on discovering one.

We observed that the injury severity scores of those who died of their injuries before reaching hospital did not suggest that immediate death was inevitable. Accepted wisdom had hitherto assumed that those who died so early from their injuries must have incurred injuries so severe that death was inevitable. The injury severity scores indicated that only a fifth of those who died before reaching hospital had injuries incompatible with life. The profile of the remainder was not dissimilar to that of those who died in hospital, although we did not investigate this difference further. Our study was focused on those who died before reaching hospital. Nevertheless, I appreciate Nicholl's efforts in providing further statistical analysis of this aspect of our study, but his findings are not central to the main theme of the paper.

We showed successfully that the death of those who died before reaching hospital was potentially preventable in many cases. Moreover, death might have been averted by simple first aid protection of the airway. It was the observation that airway obstruction was a factor that led us to the earlier work of Yates, who had also investigated airway patency in fatal accidents and used Bull's probits to predict outcome.¹ Our concerns about using this technique were expressed in the paper, but the lack of any modern British alternative highlights the paucity of work.

Nicholl agrees that norms can provide a useful tool for audit and so presumably supports our use of them in this audit of pre-hospital deaths. We made no claims with regard to effectiveness.

We identified a group of patients thought to have been unsalvageable but who might have been saved. We were careful in the paper to identify the speculative nature of giving a total of preventable deaths, but 14 patients had injuries that would not have been classified as major trauma and many others had injuries, though serious, that would not normally be associated with a fatal outcome.

Continuing concerns about statistical methods used to predict outcome from injury must not be allowed to divert attention from the indisputable findings that pre-hospital deaths from injury are not inevitable and that at least some can be prevented by simple first aid measures.

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1 Yates DW. Airway patency in fatal accidents. *BMJ* 1977;iii:1249-51.

Health and social inequality in Europe

Classification used in paper was misleading

EDITOR,—In a recent article¹ Chris Power summarised the results of two studies which we did on socioeconomic health inequalities in different industrialised countries.^{2,3} Unfortunately, the box summarising these results contains some inaccuracies which we would like to see corrected. Apart from the incorrect reference figures in the title of the box, the main problem is that our original distinctions in four groups of countries for the size of mortality differentials, and three groups

Size of mortality and morbidity differentials by socioeconomic status among adult men

Mortality:

Low	Netherlands, Denmark, Norway, Sweden
Medium low	Finland, United Kingdom
Medium high	Germany, United States
High	France, Italy

Morbidity:

Low	Norway, Sweden, United Kingdom, Spain
Medium	Netherlands, Denmark, Finland, Japan
High	Germany, Italy, Canada, United States

of countries for the size of morbidity differentials, have been replaced by a simple distinction into two classes (low and high, with the intermediate groups all allocated to the low category).

This produces several misleading impressions, such as that mortality differentials in the United States (medium high in our original classification) are low on an international scale. A correct version of the box is reproduced below. The information refers to adult men only.

Our current study, sponsored by the European Union (under the Biomed-1 programme), aims at updating and extending the analyses reported above. In that context we will also explore the explanation of these intriguing variations.

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1 Power C. Health and social inequality in Europe. *BMJ* 1994;308:1153-6. (30 April.)

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Migration from deprived areas may be a factor

EDITOR,—Peter Phillimore and colleagues' paper re-emphasises the association between material conditions and mortality patterns and states that there is evidence of increasing disparity in mortality in northern England over the past decade.¹ I wonder whether some of this increasing disparity is due to selective migration from deprived areas.

Previous studies have confirmed the association between deprivation (the Townsend deprivation score) and ill health in Northern Ireland.² It is not possible at present to replicate the work by Phillimore and colleagues because of the absence of the enumeration district data, which are necessary to enable the construction of equivalent wards so that the 1981 and 1991 censuses can be compared. It is possible, however, to track changes in mortality by district council (local authority). All 26 district councils have shown a reduction in standardised death rates between 1980-2 and 1990-2, with the more deprived areas showing the least improvement. The percentage reduction was significantly related to the net percentage change in population due to migration between the censuses ($P<0.001$). Those district councils that sustained a net loss of population exhibited the smallest