mortality at our Penrith unit averages 4.7 per 1000 births and this includes those cases transferred in labour.

Maybe the association has evidence that some small units are unsafe. Each unit is different. To suggest closure of all such units is an act of high handed interference in others' affairs. We are told that "one third of mothers require the presence of an anaesthetist during childbirth." This seems highly unlikely. Only 1.7% of women starting labour at Penrith ever needed an anaesthetist. I am sure they are grateful for that service, but the other 98.3% would not see closure as a better "choice" (sic). It would be foolish to claim that anaesthetists are irrelevant to small units which select low risk deliveries. Much of the report has excellent suggestions but the association is being overbearing in suggesting to health authorities that small units should be closed. The association can know very little about such units as it has so little contact with them. No general practitioner is acknowledged as giving advice to the association.

If safety really was the prime concern of this report, then some of the conclusions are false and would not be in the patients' best interests. It would certainly not increase the patients' choice.

A more balanced decision is needed and I would welcome a meeting of interested parties.

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2 Young G. Are isolated maternity units run by general practitioners dangerous? *Br Med J* 1987;294:744-6.

3 Cavenagh AJM, Phillips KM, Sherida B. Contribution of isolated general practitioner units. *Br Med J* 1984;288:1438-40.

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Delivery of hospital discharge letters to general practitioners

SIR,—Asking patients to deliver hospital discharge letters to their general practitioners (12 December, p 1523) has been practised in many centres. This is an efficient method of getting the information to general practitioners early, but there can be pitfalls particularly when patients wish to withhold information from their general practitioners.

In this hospital we have for the past four years used a discharge letter which consists of three sheets of carbonless copy paper. The top copy has the words "copy to GP" printed in the margin and is posted to the general practitioner at the time of discharge. The next sheet has the words "retain in patient's case record" and is inserted into the patient's case folder at discharge. The third copy is given to the patient in an envelope with instructions to hand it to the general practitioner when the next contact is made. The lower section of the letter is also used as a drug prescription sheet for take home medication, and the general practitioner can therefore see how much has actually been dispensed.

Although this form of letter requires slight duplication of effort, it does ensure the best possible chance of the general practitioner actually receiving information about the patient when it is required. Since the patients often carry their copy around with them we in the hospital have the additional advantage that it is sometimes the only information we have available when patients return to outpatient clinics and the medical records have vanished.

The local general practitioners find this helpful and it has certainly improved communication between us.

As one who firmly believes that patients can do far more than they are usually given credit for I would like to see this kind of system extended.

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Community care

SIR,—The work of a two year project funded by the DHSS looking at collaboration between district health authorities and family practitioner committees has reached conclusions that support Elaine Murphy's contention (12 December, p 1505) that general practitioners and family practitioner committees rarely participate in the planning, management, and delivery of community care services. To a certain extent this is historical. The mismatch of management resources between authorities and the independence of contractors are also limiting factors.

In City and East London, where the project is based, there are no primary care strategies agreed between the district health authorities and the family practitioner committees. There are no forums for discussing the primary health care agenda. Health authorities have joint care group planning committees to which contractors have little or no access beyond perhaps the token general practitioner, usually a local medical committee nominee. Lack of numbers prevents staff of family practitioner committees from attending these care groups. Not only are other contractors such as dentists not concerned in planning but little is done to bring in the generality of contractors in the early formulation of district health authority policies for care in the community, policies which will ultimately depend on contractors for real success.

Joint planning groups will be concerned in matters of finance, housing, and planning permission; much district health authority and local authority debate ensues. The provision of adequate services from contractors is too often simply assumed. While many general practitioners may be willing to participate more in community care and support its aims, there are those, particularly in the inner cities, whose circumstances, premises, etc, make active participation impossible. Planning groups must seek to talk to as many contractors as possible: a member of the local medical committee on a committee does not mean that the views of contractors have been properly sought or that sufficient information on the services that general practitioners provide has been vouchsafed.

The family practitioner committee's role must be one of increasing the participation of contractors in planning. The committee should seek to encourage planners to contact groups such as a general practitioner forum or a young practitioners' group. Many contractors will rely on the family practitioner committee to inform them of district health authority policies for care in the community: the committee must improve communications and develop information sharing so that planners have an accurate picture of what is available and what support it is appropriate to expect from contractors to complement their policies.

Health authorities cannot expect contractor support if their own decisions antagonise contractors. When decisions are taken by a district health authority the consequences must be understood. It is no good for a district health authority to expect contractor participation in community care if that

same authority takes decisions—for example, on FP10 prescribing or access to district health authority diagnostic and therapeutic services for general practitioners—without proper consultation.

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SIR,—Professor Elaine Murphy's articles (12 December, p 1505, and 2 January, p 6) review recent publications that reflect the government's concern to make a reality of community care. She is not yet so paranoid (or, alternatively, perceptive) as I am and so misses the point of all this concern: that cash limiting, which has been so successful in reducing hospital and community services, is to be extended to all forms of residential care, leaving the reality of community care as Hobson's choice.

There are major deficiencies in the Audit Commission's review,¹ most notably that it fails to acknowledge the greater disabilities of people in institutional care when proclaiming the "better value" of care at home. It confirms that residential provision has not increased but simply kept pace with the numbers of 75 year olds while losing beds in the most potent therapeutic sector—the hospitals. Yet there is outrage that so much has been spent on social security payments, whose recipients are caricatured as cynical money grabbers. There is now independent evidence that 93% of those receiving such payments for residential care could be managed in no other way—certainly in no other way that would be cheaper.²

Yet the radical reorganisation that the commission called for is on its way: the Comptroller and Auditor General recommends to the House of Commons "giving local authorities the responsibility for financing all residential care costs in both the public and independent sectors . . . agreement to be reached on the level of resources to be made available to local government. . . ."³

Thus, though there is little evidence that those payments have been misused, a new method of administration and cash limits are to be invoked to prevent misuse—to make a reality of community care. If such rationing is to be enforced it must be linked to the numbers aged 75 years and above, with an extra loading for those over 85 years in a locality. Limits linked only to the numbers aged 65 years would be unreasonable and punitive. Whatever arrangements are made seem likely to reduce the freedom of choice of old people to move to new localities by limiting the numbers of places funded within each locality. So much for freedom. This is the harsh reality of community care.

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2 Social Research Unit. *Supplementary benefit residential care assessment report*. University of York: Department of Social Policy and Administration, 1987.

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Hyperbaric oxygen for carbon monoxide poisoning in England

SIR,—Drs Tim Meredith and Allister Vale in their leading article (9 January, p 77) advocate the use of hyperbaric oxygen for this condition. The following National Health Service hyperbaric