are shorter and of a finite duration. Our qualifications, both public and private, were that a large increase in the number of consultants was needed, which would require greatly increased resources, and that the scheme should be introduced gradually over 10 years.

Fourthly, many of the questions posed in table I of the paper are only tangentially relevant to the Calman proposals, relating more to the reduction in junior doctors' working hours, shortages of senior house officers, and increased emergency workload. Implementation of the proposals will indeed exacerbate the pressures, but, as the college has said and Mather and Elkeles reiterate, these can be mitigated by slow implementation and the increased funding necessary to pay for more trainees and more consultants. To this end, the secretary of state has recently announced that transitional funding will be made available. Perhaps more to the point is the understandable reluctance of consultants, who have long since stopped doing residential shift work, to return to the practice. If there is to be a move in this direction—which has little to do with the Calman proposals—then there will indeed have to be a large increase in the consultant workforce so that rotas can be established that will allow sufficient time for recuperation after nights on call.

Fifthly, the paper mentions the lapse of consultants' technical skill in handling medical emergencies. There should be no more bar to consultants refurbishing old skills than there is to trainees acquiring new ones.

Finally, the authors' table I omits one notable question: Have you read the proposals in full?

The message communicated by Mather and Elkeles is a gloomy one, but stronger forces than the Calman report contribute to it. The report is surely a step in the right direction and should be warmly received by all who believe that defined training programmes with set end points contribute to raising the standards of care.

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Proposals do not refer to need for consultant provided service

EDITOR,—Hugh M Mather and Robert S Elkeles report the outcome of a questionnaire survey of the attitudes of consultant physicians in North West and South West Thames regions to the Calman proposals.¹ They state that the specialist training reforms demand a change to a "consultant provided service." Nowhere in either the chief medical officer's report *Hospital Doctors: Training for the Future*² or the subsequent documentation is there any reference to the need for a consultant provided service. Indeed, the only specific reference in the report to changes in medical staffing policies is to the likelihood "that there will be an increase in the proportion of care provided by the consultant grade and a greater demand for consultant posts within the NHS."

It should be emphasised that one of the first results of the Calman reforms is likely to be an increase in middle grade staff. This will happen as resources are diverted into specialist training programmes to meet the difficulties that trusts are currently encountering in filling consultant posts in key specialties, including general medicine. Mather and Elkeles's paper refers to the discussion document published by the Committee of Postgraduate Medical Deans and the UK Conference of Postgraduate Deans, which states that the involvement of consultants in the provision of emergency care will need "to be extended."³ This

is far from implying that consultants will be required to provide front line 24 hour cover as Mather and Elkeles suggest.

The paper raises interesting questions about the perception of consultant physicians in the west Thames area in relation to acute medical practice and the ways in which this may be delivered. It is wrong, however, to centre the arguments arising out of this paper on either the Calman report or the report on training for senior house officers.

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Present situation is detrimental to patient care

EDITOR,—In their recent postal survey of a representative group of consultant physicians, Hugh Mather and Robert Elkeles identified widespread opposition to the Calman proposals.¹ Sadly, 70% or more of respondents admitted to not having recent experience in performing three essential lifesaving procedures and, more disturbingly, 47% of these were unwilling to relearn these skills. This implies that they would have limited ability to teach these procedures to their trainees.

As practitioners in acute specialties, these consultant physicians are presumably responsible for the care of sick patients and the education of their trainees. Most of the respondents (70%) work at district general hospitals and are now presumably buffered from their patients by fewer tiers of trainee staff. If it is accepted that doctors caring for seriously ill patients should be capable of resuscitating them, it is a shame that most of the respondents admit their inability to perform basic lifesaving techniques.

This sorry state of affairs can only be detrimental to patient care, regardless of whether consultants are prepared to return to residential emergency duties and take on responsibility for the education of their successors. Implementation of the Calman proposals, together with the recognition of the requirement for continuing medical education (which should include training in practical skills) must be accepted to improve patient care. Rather than adopting a negative attitude, consultant physicians should support these advances and fight to achieve the necessary expansion in resources.

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Rising emergency admissions

EDITOR,—The King's Fund and NHS Trust Federation's recent report on the rise in emergency medical admissions over the past three years rightly rejects demographic change as an explanation for short term variation in such admissions.¹ The current upsurge in admissions, however, is occurring against the background of a gradual long term increase, which could well be associated with demographic change.

Although demographic change is usually taken to refer to the increase in the elderly population, living alone is also a risk factor for admission to hospital, probably because people living alone do not have a carer in acute social or low grade medical crises. Examination of census data for people aged 60 and over in private households shows an increase in those living on their own from 18.8% of households in 1971 to 30.8% in 1991. In a recent case-control study carried out in people aged 60 and over, data were collected from hospital controls, patients admitted with acute medical problems, and community controls.² Among the hospital controls from private households 33.5% (372/1111) lived on their own, while among the community controls the figure was 29.2% (288/985). The odds ratio for living alone as a risk factor for emergency admission, corrected for underlying illness, was 1.3 (95% confidence interval 1.06 to 1.60). Use of this result to calculate the population attributable risk indicates that a tenth of all emergency medical admissions in this age group are attributable to living alone.

One of the inefficiencies in the NHS highlighted by Archie Cochrane was the incorrect place of treatment.³ Allowing general practitioners to have access to cottage hospitals or nursing home care could help mitigate the strain currently placed on the acute hospital sector.

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Patients prefer hospital follow up for cancer

EDITOR,—The response to John Dewar's call for a reappraisal of follow up care for patients with breast cancer¹ shows the gap between patients' and general practitioners' views on this topic. While Eva Grunfeld and colleagues report general practitioners' preference for a system of follow up in general practice,² qualitative data from patients show their preference for hospital follow up, which is perceived as the "best defence against a recurrence of their cancer."³

Our failure to discharge long term survivors of cancer from the oncology clinic led to a programme of planned discharge, during which we sought patients' views on important components of care in general practice, specifically in relation to patients with cancer. Thirty nine patients who had agreed to be discharged were interviewed four months later and completed a questionnaire. In parallel, 38 registrars in general practice attending courses at Michael Sobell House, Mount Vernon Hospital, were polled with the same questionnaire (response rate 90% (n=34)). Participants were asked to rate the importance of 13 components of care. The figure shows the mean scores of both samples. Significant differences in the importance of skill in managing cancer ($t=5.11$, $P<0.0001$, $df=73$) and up to date knowledge of modern drugs ($t=-3.83$, $P<0.001$, $df=68$) show the much greater emphasis that patients put on medical skill. These results reinforce those of Grunfeld and colleagues and Jane Maher and colleagues and highlight the mismatch of expectations between doctors in

Importance of 13 aspects of care in general practice, as rated by 39 patients with cancer (pale stippling) and 34 registrars in general practice (dark stippling)

primary care and patients regarding the fulfilment of optimum follow up.

The trainees in general practice showed an awareness that follow up does not influence survival, and their view of the usefulness of skill in the management of cancer may be the more rational approach. But for patients entrenched in the system of hospital follow up, specialist knowledge and clinical examination are the sources from which reassurance is derived.

The present system of follow up in breast cancer maintains the myth that lives are thereby saved and emphasises to the patients that the doctor is actively seeking to find a recurrence. Little wonder that women value skill in cancer and fast track referral to hospital oncology services. Is this the way to build up coping strategies or to rehabilitate and empower women? If we are to develop a follow up programme flexible enough to meet individual patients' needs these issues need to be addressed.

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Nurse triage may reduce workload in accident department

EDITOR,—We read the editorial by Andrew B Bindman¹ and the two articles by Jeremy Dale and colleagues^{2,3} on triage in accident and emergency departments with interest. With the ever increasing number of patients presenting to accident and emergency departments, a stricter triage system and, perhaps, a new approach to deal with the

problems are needed. As Bindman suggests, there can be no gold standard for determining the appropriateness of visits, and accurate triage guidelines are impossible to develop.

At Liverpool we now have a new, amalgamated ophthalmic primary care department, which has replaced the ophthalmic accident and emergency department and caters for all ophthalmic accidents and emergencies as well as providing a service for patients with less urgent needs. Such an amalgamated unit would certainly reflect the philosophy of the report of the royal commission on the NHS quoted by Dale and colleagues.⁴ Given general practitioners' low level of undergraduate training and postgraduate experience in specialties such as ophthalmology, traditionally the primary care in such branches is provided almost entirely by accident and emergency departments.

A recent audit showed that only 15% of patients attending our ophthalmic department were true emergencies. In our triaging system a short nursing history is supplemented by some objective tests, such as assessment of visual acuity and measurement of intraocular pressures, to increase the accuracy of triage. If the triage nurse deems the problem to be non-urgent the patient, whether self referred or referred by a general practitioner, is either seen by a doctor on the same day (if staffing permits) or given an appointment for a primary care clinic. A nurse practitioner can be of immense help in reducing the workload and waiting times in an accident and emergency department. We believe that a prospective study is warranted to elucidate the effectiveness of nurse practitioners in these departments.

In both of Dale and colleagues' studies most of the workload was shared among the senior house officers. A better mix of staff, with more senior medical staff, might contribute to a more efficient primary care setting. It is interesting to learn that employing a general practitioner in an accident and emergency department resulted in reduced rates of investigations, prescriptions, and referrals. Such a move in specialty accident and emergency departments has the potential to improve the quality of primary care in the community for patients with problems that would be otherwise referred to hospital specialists.

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Strengths of carotid endarterectomy were understated

EDITOR,—We take issue with some of the statements that Wendy Taylor and Georges Rodesch make about carotid endarterectomy in their article on interventional neuroradiology.¹ They state that one of the advantages of carotid angioplasty over surgical removal of the plaque is that general anaesthesia is unnecessary. Most carotid endarterectomies are performed under general anaesthesia in Britain, though the operation can be done under local anaesthesia and this is common in the United States and South America. The authors also state that there is a 1-2% risk of complications with angiography. While angiography is unavoidable with carotid angioplasty, many centres in Britain are happy to undertake surgery on the basis of Duplex scanning alone.

The authors state that the patients' stay is shorter with angioplasty than with surgical endarterectomy but do not give any figures or references for this statement. At Guy's Hospital we have analysed the length of stay of patients having carotid endarterectomies over the past four years. The figure shows that the median length of stay has fallen from seven days in 1992 to two days in 1995.

Length of stay after carotid endarterectomy, Guy's Hospital, 1992-5

Four of the 123 patients developed complications: all four had strokes, which were permanent in two. No deaths occurred. A recent survey of a broad range of surgeons by the Vascular Surgical Society showed much lower complication rates than those quoted from the European and North American symptomatic carotid endarterectomy trials.

One further point not alluded to in the article is the considerable residual stenosis and the clinical consequences of this after balloon angioplasty.

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