Infectivity of pneumonic plague

EDITOR,—Peter Cowling and Peter Moss support the view that pneumonic plague is highly infectious.¹ It is certainly lethal unless treated vigorously at an early stage by antibiotics. This, however, does not prove that it is highly infectious as, say, measles or influenza is. Of the patients in an overcrowded ward during a large outbreak of plague in Kenya in the 1940s, only one certainly and one probably acquired the disease in the ward. The certain case was in a paralysed patient occupying the bed next to a patient who died expectorating *Yersinia pestis*. Most of the patients dying of plague whose lungs were affected were in the last stages of bubonic plague, but the diffuse pneumonia in the lungs of others indicated true pneumonic plague—that is, plague acquired by inhalation of the bacillus.

An outbreak of pneumonic plague also occurred in Tanzania in 1972; the disease was brought into a village by a hunter, who presumably carried fleas or flea faeces from an infected wild rodent. A sharp outbreak ensued, which was confined to adjacent huts or intermingling relatives. Before the diagnosis was made a medical attendant in a local mission hospital died of pneumonic plague acquired from a patient. Once the diagnosis was made no further fatalities occurred in hospitals, the nurses and medical attendants being protected by a sulphonamide or streptomycin. Only one other fatal case occurred in the village after the whole population was given a prophylactic sulphonamide. The diagnosis was later confirmed by serological testing in a specialist laboratory. I was present throughout both of these outbreaks.

The notorious epidemic in China at the beginning of the 20th century took place under intensely cold conditions, when the subjects slept huddled together in small circular huts. Close proximity to the sufferer seems to be necessary for transmission of the disease. The differing death rates from bubonic plague before the introduction of sulphonamides or antibiotics indicated that the virulence of *Y pestis* varied, and possibly the degree of its infectivity also varies.

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1 Cowling P, Moss P. Infectivity of pneumonic plague. *BMJ* 1994;309:1369. (19 November.)

Certifying incapacity for work

EDITOR,—The item in *Medicopolitical Digest* concerning proposed changes to the certification of medical incapacity for work may mislead doctors about the changes that have been proposed for the introduction of incapacity benefit next April.¹ Ministers announced last year that, as part of the changes, the role of general practitioners as gatekeepers to long term incapacity benefits would be greatly reduced. Entitlement to incapacity benefit after the first six months of incapacity will be determined by the application of a new "all work" test. Once this test has been applied general practitioners will no longer need to issue medical statements to certify continuing incapacity for work. At no time have we proposed asking general practitioners for an opinion on eligibility to incapacity benefit. Furthermore, from next April the law would not allow it.

Most spells of absence due to sickness are for shorter periods and involve a claim for statutory sick pay administered by the patient's employer. General practitioners currently issue Med 3 certificates for this purpose, and there are no plans to change this arrangement. Nor are there any plans to change the current arrangement for self certification during the first seven days of incapacity.

It is of paramount concern that patients who are

incapacitated for work are supported in their claim to state benefits with appropriate clinical information about their condition. The patients' own doctor is the person best placed to supply such clinical detail, and we have not sought to alter this.

We have proposed a new medical statement for use in incapacity benefit, which, for the first time, will allow general practitioners to provide a certificate to their patients for social security purposes only. Provision of this statement, which will be within general practitioners' current terms of service, also gives doctors the opportunity to include a full diagnosis of the condition(s) causing incapacity for work. As a result we expect a substantial reduction in the number of occasions when the Benefits Agency medical services request a factual report (RM2) from the patient's doctor. We have also proposed replacing the standard RM2 forms so that doctors give a more focused and relevant report on the patient. Far from increasing general practitioners' workload, these proposals are aimed at substantially reducing long term certification work and the number of medical reports that general practitioners are obliged to complete.

In developing our procedures we have taken careful note of all the concerns expressed by the profession and the representative bodies. General practitioners we have spoken to have welcomed these proposals and are happy to support their patients by supplying appropriate medical information. We have liaised closely with the BMA over these proposals, and I am disappointed at the stance taken recently by the General Medical Services Committee.

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1 Beecham L. GPs will not police social security system. *BMJ* 1994;309:1163. (29 October.)

Determining the number of psychiatric beds needed

EDITOR,—We support Graham Thornicroft and Geraldine Strathdee's view that it is not possible to debate the issue of how many psychiatric beds are needed without placing the emphasis firmly on the whole mental health system.¹ But the notion that pressure on inpatient beds could be eased by more efficient management by "senior clinical gatekeepers" is too simplistic. The suggestion that the crisis in acute inpatient services would end if only clinicians managed their services properly is being repeated so often that it is beginning to be believed. As with all such statements, there is some truth in it, but it does little for the morale of an already demoralised service and provides the Department of Health with another stick with which to beat clinicians rather than encouraging the department to confront the real issue of resources.

The purchase of acute admission beds within the private sector has increased considerably to compensate for their lack in the NHS, and this has become a regular feature of many acute units in London. This change in provision is aligned in our service to a decrease in the overall number of admissions from 1459 in 1992-3 to 953 in 1993-4 with a pronounced increase in the average length of stay (mean 21.4 days in January 1994 and 31.5 days in September 1994). The percentage of detained patients has also increased considerably, from 40% (589/1459) to 58% (553/953). These changes have occurred despite no absolute reduction in beds occurring and alongside the development of our increasingly effective community mental health service.

The length of stay increased most after the introduction of the care programme approach and

the first phase of the supervision register. When used properly the care programme approach slows throughput, and there is no doubt that community teams and consultant psychiatrists are now far less willing to take risks concerning discharge; previously, taking such a risk was the only means by which a bed could be freed for a potentially more disturbed patient. Mental health teams managing their own beds from admission to discharge is an exciting model being implemented in some services, including our own, and should lend a coherence to patients' care, but whether this model will result in a reduction in the number of beds required has yet to be proved.

The need for safe standards in community services has been recognised. We would point out, however, that while minimum safe staffing levels operate for inpatient units, these units are increasingly experienced by patients and staff as threatening and at times dangerous environments.

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1 Thornicroft G, Strathdee G. How many psychiatric beds? *BMJ* 1994;309:970-1. (15 October.)

Ethics of rationing health care services

EDITOR,—Unlike Raanon Gillon,¹ I find myself agreeing with the King's Fund when it advocates the formation of a Oregon-like commission modelled on the Nuffield Council of Bioethics to start the process of rationing of specific services.²

Gillon doubts whether it is morally safe to use, as he sees it, "populist solutions in distributive justice such as have occurred in Oregon . . . and technical and simplistic economic solutions such as the system of costed quality adjusted life years (QALYs)."³ Instead he favours seeking ways of "muddling through elegantly" as advocated by Hunter in *Rationing Dilemmas in Health Care*.³ Gillon is offended by moral choices being converted into apparently scientific numerical methods and formulas.

His criticism seems to centre on the notion that every case must be considered on its merits. By focusing on the admittedly pseudoscientific formulations used (Alan Maynard described the ranking process used in Oregon as nothing more than a crude guesstimate),² he fails to address the underlying issue of whether it is morally right in principle to decide on what a person is entitled to expect from the health service and what that person should not expect from the health service. Surely one person's elegant muddling is the same as another's irrational decisiveness. How are we to tell the difference?

In a just health system a patient should be able to expect equality of access to health care which is free at the point of service,⁴ in the way which was originally intended 46 years ago. To my mind, this is not to be achieved by elegant muddling. Elegant muddling implies an unwillingness to face up to hard choices.

Gillon quotes Calabresi and Bobbitt, who suggest that health professionals are like jugglers trying to keep too many balls in the air;⁵ like the juggler we must do our best to improve our juggling skills to keep more balls in the air for more of the time and to avoid letting any ball stay on the ground for too long.

Working as a general practitioner in the NHS for the past 10 years I too have often used the analogy of the juggler: all the balls are not equal—more harm is caused if we drop some balls than if we drop others. I together with many of my colleagues have become demoralised and exhausted juggling with so many balls. Every so often someone throws yet another ball our way. We are finding that it is less and less enjoyable to juggle—what is more, we are dropping more and more balls and too many are getting damaged.

In my metaphor the balls represent medical condition-treatment pairs. An imagined contract with our patients might go like this: would you allow us to drop breast reconstruction after mastectomy so that we can guarantee that we will always be able to treat triple vessel coronary disease within three months? By advocating explicit rationing, I am suggesting that we health workers drop some of the balls so that it becomes a joy to juggle again. The consequence of this is that the balls which really matter will stay in the air.

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- 1 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309:184-8. (16 July.)
- 2 Honigsbaum F. *Who shall live? Who shall die? Oregon's health financing proposals*. London: King's Fund College, 1994. (King's Fund College papers No 4.)
- 3 Hunter DJ. *Rationing dilemmas in health care*. Birmingham: National Association of Health Authorities and Trusts, 1993. (NAHAT research paper No 8.)
- 4 Macara AW. Reforming the NHS reforms. *BMJ* 1994;308:848-9.
- 5 Calabresi G, Bobbitt P. *Tragic choices*. New York: Norton, 1978.

Electronic health records

EDITOR,—Dipak Kalra mentions strategies for entering clinical data in the context of advanced informatics in medicine projects, including the possibility of—"further into the future—voice input."¹ As the result of a collaborative project between Belfast City Hospital, the directorate of information systems (Management Executive, Northern Ireland), and IBM we can directly input radiology reports by using voice recognition technology. We have used the IBM speech server series software and a specially developed radiology dictionary and language model for one year. This operates on personal computers and is directly integrated into our existing radiology management and computer system (Northern Ireland radiology system), which was developed by the directorate of information systems. As a result, voice input reports can be viewed on remote terminals throughout the hospital as soon as they have been produced.

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- 1 Kalra D. Electronic health records: the European scene. *BMJ* 1994;309:1358-61. (19 November.)

War pensions

EDITOR,—Clare Dyer reports that a war pension has been awarded for "desert fever."¹ This is incorrect.

Both British and American authorities have maintained a close watching brief on the health of personnel who participated in the Gulf war. Despite considerable study the existence of a discrete entity—Gulf war syndrome or desert fever—has not been confirmed. Research is continuing, and in Britain the Ministry of Defence has

a programme for investigating participants in the Gulf war who are suffering apparently unexplained symptoms.

The British war pensions scheme is generous in its provisions. To succeed, a claim for a war pension needs to relate service factors to the cause or course of the claim disablement. For claimants who have recently been released from service the legislation is particularly generous. There is no onus on former service personnel to prove their case. For a claim to be rejected the department must prove, beyond reasonable doubt, that service factors played no part in the cause or course of the medical condition(s) giving rise to the claimed disablement.

So far no war pension has been awarded for Gulf war syndrome or desert fever. All pensions currently being paid to personnel who participated in the Gulf war are in respect of recognised medical conditions.

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Careers in academic general practice

EDITOR,—Although an occupant of the corner so clearly fought for by Aly Rashid and colleagues in their recommendations on the need to increase general practitioners' contribution to teaching and research,¹ I am concerned that those in other corners will view their paper as a polemic, or at best a case of special pleading. Historically, general practice has been service dominated. The opportunity for rapid attainment of principal status (compared with consultant status) has made acquiring research experience in junior academic posts unattractive financially. With respect to teaching, however, the vocational training grant "buys" protected teaching time, and the service contribution of trainees is not insignificant. To imply that specialist academic colleagues have it easy and do not face the same difficulties in balancing teaching research, and service demands is unnecessarily divisive.

Certainly core funding for research is a problem as it is for most non-undergraduate NHS teaching hospitals—also non-recipients of the service increment for teaching research (SIFTR). An equitable redistribution of the service increment for teaching (SIFT) will be welcomed by all those involved in undergraduate teaching, not just general practitioners. The research component of the service increment will be under the management of regional research and development directors, and the Culyer report makes a commitment to equity in funding research and development in primary care.²

Most importantly, although Rashid and colleagues assert that the achievements of academic general practice have been considerable, they paint an unnecessarily gloomy picture of its current status. By quoting outdated research on obtaining higher degrees from general practice they fail to acknowledge the considerable improvements occurring. The Royal College of General Practitioners recently published an impressive (yet incomplete) list of doctors recently qualified as MDs.³ Nor do the authors mention the burgeoning number of MSc courses specifically for, or relevant to, general practitioners. Finally, the statements about continuing separations of undergraduate and postgraduate general practice are surely too pessimistic. Surprisingly, Rashid and colleagues do not mention the Conference of Academic Organisations in General Practice, which has representation from all aspects of the discipline. This body is working with some success towards coordination of academic activity in general

practice.⁴ In my own department we have a shared agenda, including joint appointments, with the regional adviser's department. The "long term objective" of integration of departments is laudable, but this should not be to the exclusion of integration with colleagues in other disciplines. We are not seeking islands of general practice academia, but a strong primary care base within the whole of academic medicine.

The tide is already starting to run in favour of academic general practice. We need to grasp the opportunities that are presenting themselves and show others that we can deliver, rather than plead for our share of preferential treatment.

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- 1 Rashid A, Allen J, Styles B, Pereira Gray D. Careers in academic general practice: problems, constraints, and opportunities. *BMJ* 1994;309:1270-2. (12 November.)
- 2 Culyer report. *Supporting research and development in the NHS*. London: HMSO, 1994.
- 3 Royal College of General Practitioners. MD theses. *Connection* 1994;Octvii.
- 4 Conference of Academic Organisations in General Practice. *Research in general practice*. London: Royal College of General Practitioners, 1994.

Out of hours care

Cultural change is necessary

EDITOR,—David K Cragg and colleagues found that the reason most commonly cited by patients for not attending out of hours primary care centres was not having a car available.¹ This was despite population statistics showing no difference in car ownership between electoral wards of attenders and non-attenders. One interpretation of this is that, although patients did have access to a vehicle, other priorities or unwillingness to attend for other reasons were more relevant. I wish to report data from a current study of unselected patients requesting home visits out of hours via the deputising service in Southampton, an urban conurbation broadly similar to the conurbations in Cragg and colleagues' study. A policy of visiting all patients specifically requesting a visit is adopted; at the time of the study an out of hours assessment centre was not generally available as an alternative.

Patients were not questioned about issues such as transport before the visit, but at the end of the consultation the visiting doctor administered a brief questionnaire to collect data. On 1023 consecutive visits we found that 395 (39%) patients or families did not possess a car. This compares well with the overall figure of 40% reported by Cragg's and colleagues. Furthermore, 204 patients did not have a telephone in their home, 258 lived in council blocks of flats or bedsits, and half were in social classes 4 and 5. These figures confirm the substantial use of out of hours services by those in poorer socioeconomic circumstances, who indeed have difficulties of access to health care—an issue that will remain a problem for planning in urban areas particularly.

One hundred and thirty nine patients in our study had seen another doctor within the previous 24 hours, and three quarters of this group required only reassurance or advice about over the counter treatment. Furthermore, there was no overall statistical relation between the type of level of treatment started and factors such as social class. This indicates that perceived need is the dominant factor and supports the conclusion that a major cultural change will have to occur before out of hours centres become more acceptable.

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