(36%) should also be viewed with concern. Changes in personality can be induced by exposure to chemicals; some people may be more susceptible than others. Many men reported serious side effects after taking nerve agent pretreatment sets, including enhanced aggression. These reports should be investigated thoroughly.

We must protect our troops as well as possible in modern warfare. That implies an objective approach to all complaints after service in a particular field. It is to be hoped that the Ministry of Defence will now ensure thorough research into its own findings, preferably through civilian and NHS establishments.

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1 Revell T. The Gulf war syndrome. *BMJ* 1995;310:1073. (22 April.)

Transferring the costs of expensive treatments

Guidelines may clarify responsibility for prescribing

EDITOR,—Bromley Health has looked at ways of dealing with the transfer of expensive treatments from secondary to primary care.¹ As a unified district health authority and family health services authority, it is ideally placed to deal with general practitioners' concerns, such as cost shifting, by making changes in the contracts with providers.

Bromley Health's approach has been to draw up a list of drugs to be prescribed by hospital doctors and not by general practitioners. This advice is founded on clinical responsibility and not cost and is based on a document from the NHS Management Executive.² The advice given is that "when clinical, and therefore prescribing, responsibility for a patient is transferred from hospital to GP, it is of utmost importance that the GP has full confidence to prescribe the necessary drugs." The test in confidence is whether the general practitioner "can monitor treatment and adjust the dose if necessary." For example, monitoring of growth hormone treatment or the adjustment of the dose of erythropoietin is done by a specialist, and therefore the specialist should issue all necessary prescriptions.

The list of drugs is managed by Bromley Health's prescribing committee. It is envisaged that new drugs will be reviewed for inclusion—for example, when limited trial data exist, as in the case of interferon beta, or when the place in treatment is not fully established, as with domase alfa. But the prescribing committee relies on evidence from regional specialist advisory committees, and, with their passing, purchasers will need to collaborate to obtain specialist advice.

One barrier has been communication between hospital managers and hospital doctors. While managers accepted that the consultants should prescribe if the general practitioners felt unable to, the doctors continued to defend their directorate budget as they had been instructed not to overspend.

There is a cost to Bromley Health. The guidance that specific drugs should be prescribed entirely by the hospital doctor will be reflected in the contracts with providers. The contract price will include the cost of these drugs and will therefore reflect the full cost of treatment. By deliberately limiting access to the general practitioners' drug budget, which is not cash limited, Bromley Health will have to increase financial resources for the purchase of hospital services.

Bromley Health hopes that its guidelines will clarify responsibility for prescribing. Moreover, by avoiding the separation of prescribing from the

assessment of treatment, hopefully it will ensure that treatment is effective and appropriate.

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1 Crump BJ, Panton R, Drummond MF, Marchment M, Hawkes RA. Transferring the costs of expensive treatments from secondary to primary care. *BMJ* 1995;310:509-12. (25 February.)

2 NHS Management Executive. *Responsibility for prescribing between hospitals and GPs*. London: Department of Health, 1991. (EL(91)127.)

Review of funding is long overdue

EDITOR,—The Child Growth Foundation wishes to ask why it is only now that doctors are calling for an urgent review of the impact of transferring the costs of expensive treatments from secondary to primary care.¹ To guarantee the Department of Health's promise that patients would get the drugs they needed regardless of cost a review was needed when biosynthetic growth hormone was introduced in 1985. In fact, we wrote to the then prime minister, Margaret Thatcher, predicting that a prescribing problem would occur once this expensive drug came on the market.

We believed that the problem might be resolved after the House of Commons health committee expressed hope that someone in the Department of Health was addressing the issue, but nothing emerged.² We trust that doctors will succeed where our parliamentarians have failed.

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1 Crump BJ, Panton R, Drummond MF, Marchment M, Hawkes RA. Transferring the costs of expensive treatments from secondary to primary care. *BMJ* 1995;310:509-12. (25 February.)

2 NHS Executive. *Prescribing expenditure: guidance on allocations and budget setting for 1995-6*. Leeds: NHSE, 1995. (EL(95)8.)

Future of intensive care

EDITOR,—The recent headlines concerning the lack of intensive care beds in the United Kingdom reflect a longer term crisis that has afflicted intensive care since the first intensive care units were established around 30 years ago.

Intensive care units in Britain are still staffed by consultants, many of whom have undergone no systematic training in the specialty, and by resident rotating junior staff, who spend just enough time in the intensive care unit to learn what it is about before moving on. The royal colleges have been talking about training in intensive care for around 10 years now; they have formed one committee after another, written reports, and even established a few training posts, but essentially the situation is unchanged.

Inadequate sessional time is allocated to intensive care so that 24 hour consultant cover is generally achieved by individual consultants sacrificing their free time, and on occasion by subsidy from helpful anaesthetic departments. The plight of consultants in intensive care units is made worse by the fact that often junior staff are thrown into the unit without training, and it is not surprising that the treadmill of intensive care life militates against the development of their academic activities.

Units are too small, so that full time intensivists cannot be justified, and consultant cover is generally provided by consultant anaesthetists working in the unit one day a week or possibly one week in four or five. Neither situation allows the development of clinical teaching or research expertise in the specialty.

In Europe, North America, and Australasia, intensive care medicine is a fully fledged specialty, sometimes allied to anaesthesia, medicine, or surgery, but with formal training programmes, specialist registration, and academic departments to promote research. In the United Kingdom the Intensive Care Society has valiantly tried to develop intensive care on a multidisciplinary basis and has had notable success in the audit of outcome from intensive care. Nevertheless, progress in developing the specialty has been hamstrung by the perceived divided loyalties of physicians and anaesthetists working in intensive care and, more importantly, by the sectional interests and jealousies of the royal colleges.

To elucidate the attitudes of practising consultant "intensivists" we circulated a questionnaire to 566 consultant members of the Intensive Care Society. From 325 replies (90% anaesthetists) there was an overwhelming desire for intensive care to be recognised either as a separate specialty (24%) or as a distinct subspecialty of both medicine and anaesthesia (50%). A total of 69% of respondents wished the specialty to be governed by an intercollegiate faculty or a college of intensive care; 76% wanted a diploma examination, either a European diploma or a diploma of an intercollegiate faculty rather than of a single college. Most importantly, over 75% of respondents felt that at least two years' dedicated experience of intensive care work was required before accreditation.

There is clearly a consensus among those who work in intensive care that the current state of this increasingly important branch of medicine cannot continue. Intensive care must be recognised as a distinct specialty and the royal colleges must establish an intercollegiate faculty or facilitate reorganisation, formalise training, and stimulate academic activity in intensive care with the utmost urgency.

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Communicating with non-English speaking patients

EDITOR,—In a multicultural society and one in which modern travelling has made it easy to commute, in any country the medical services may be faced with a patient who does not speak the national language. Our *International Translation Guide for Emergency Medicine* helps medical staff to evaluate and examine patients, can facilitate communication between the travelling public and health care providers of a different culture and language, and also can lead to an adequate doctor-patient interaction.¹

Voluntary organisations have produced leaflets in different languages, but this book attempts to help the patient from the moment he or she enters into a dialogue with a health care provider. The book is simple and can be used for combinations of two languages—English, Russian, Hindi, Italian, French, German, Spanish. No knowledge of more than one language is required. It is in the format of questions and yes-no answers. Although the book could be translated into more languages, in its present form it can be used in emergency departments and general practices worldwide, and its simplicity and usefulness will be appreciated by medical and nursing staff.

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1 Bodiwala GG, McCaskie AW, Thompson MM. *International translation guide for emergency medicine*. Oxford: Butterworth-Heinemann, 1992.