Key messages

- Under the Calman proposals it is envisaged that acute medical services will be provided directly by consultants
- This study shows that most consultant physicians are not prepared to do this
- Most have not recently performed important practical procedures and would require retraining
- Most consider that the impact of the proposals on the quality of patient services will be detrimental

Fourthly, and most importantly, nearly all consultants thought that the proposals would have a detrimental effect on the quality of patient care at their hospital. This clear consensus view emerged equally strongly from teaching and district general hospital consultants and from colleagues in all specialities. This is in sharp contrast to the expressed aims of the Calman

proposals, which are intended to improve patient care, but is nevertheless the informed opinion of a large and representative group of senior clinicians who are actively concerned in day to day patient care and are well placed to assess their potential impact.

These results emphasise the widespread concern and deep antagonism of most consultant physicians towards the Calman proposals. We would be very interested to know whether these views are shared by other groups of colleagues, particularly by those in the training grades.

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Conflict of interest: None.

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Randomised controlled trial assessing effectiveness of health education leaflets in reducing incidence of sunburn

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Exposure to the sun and severe sunburn are associated with an increased risk of malignant melanoma.¹ Health education leaflets are often part of primary prevention strategies which aim to modify high risk behaviour related to the sun.² This study aims to assess the effectiveness of a health education leaflet in reducing sunburn.

Subjects, methods, and results

The study population comprised holidaymakers travelling on Air UK Leisure flights from Manchester airport during August 1993. The unit of randomisation was the flight. Flights were stratified into long haul (North America and Jamaica) and short haul (Europe) and randomly allocated to the intervention or control arm. Before boarding, the health education authority leaflet *If You Worship The Sun, Don't Sacrifice Your Skin* was placed in seat pockets on flights in the intervention arm but not in the control arm. Cabin crew distributed questionnaires to passengers on Air UK Leisure return flights to Manchester. A history of sunburn was elicited by the question "Did you suffer from any sunburn during your recent holiday?" and, if so, whether this was associated with one or more of: redness of the skin, blistering of the skin, pain for less than a day, pain for more than a day. Adults completed the questionnaire for children. The study endpoint, severe sunburn, was defined as any episode of sunburn which was either painful for more than a day or resulted in blistering. Randomisation by group was undertaken to reduce contamination between the study arms. A clustering parameter was calculated for the study endpoint. Brier's adjusted χ^2 was used for baseline comparisons,³ and 95% confidence intervals were constructed for the difference in proportions

using methods appropriate to group randomised trials.⁴

Sixteen long haul and 62 short haul flights were randomised to the intervention arm and 15 long haul and 62 short haul flights to the control arm; 21 611 questionnaires were distributed and 14 956 (69%) returned. A total of 2483 questionnaires completed by passengers who had not departed from Manchester airport during the study period and 88 inconsistent or illegible questionnaires were excluded from the analysis, leaving 12 385 evaluable questionnaires. The clustering parameter was 0.02. The study had a power of 90% to show a 5% difference between the two groups at the 5% two sided significance level. There was no significant difference between the two groups in the distribution of baseline characteristics or the proportion reporting severe sunburn (see table).

Baseline characteristics and incidence of severe sunburn in intervention and control groups. Values are numbers (percentages) of subjects unless stated otherwise

	Intervention (n=6276)	Control (n=6109)
Age group (years):		
Median	32	33
Range	0-97	1-88
Sex:		
Male	2885 (46.0)	2777 (45.5)
Female	3273 (52.1)	3233 (52.9)
Not recorded	118 (1.9)	99 (1.6)
Duration of holiday:		
0-7 days	841 (13.4)	1058 (17.3)
8-21 days	5435 (86.6)	5051 (82.7)
Hair colour:		
Blonde	2152 (34.3)	2065 (33.8)
Red	230 (3.7)	271 (4.4)
Brown/black	3699 (58.9)	3566 (58.4)
Other	107 (1.7)	97 (1.6)
Not known	88 (1.4)	110 (1.8)
Skin colour:		
Fair, never tans	160 (2.5)	185 (3.0)
Fair, gets a pale tan	2161 (34.4)	2066 (33.8)
White skin, tans easily	3114 (49.6)	3057 (50.0)
Mediterranean	593 (9.5)	580 (9.5)
Brown	151 (2.4)	136 (2.2)
Black	37 (0.6)	17 (0.3)
Other	31 (0.5)	26 (0.6)
Not known	29 (0.5)	32 (0.5)
Incidence of severe sunburn: *†		
All flights	1013 (16.1)	1053 (17.2)
Short haul	717 (16.3)	793 (17.1)
Long haul	296 (15.7)	260 (17.7)

* χ^2 (1 degree of freedom):

†95% Confidence interval for difference in proportion:

All flights 0.731 (P=0.392); -0.014 to 0.036

Short haul 0.276 (P=0.6); -0.022 to 0.038

Long haul 1.288 (P=0.256); -0.014 to 0.052.

Comment

This leaflet did not seem to reduce the incidence of severe sunburn. Passengers were not asked if they had seen or read the leaflet as this might have influenced their response to the questionnaire. Therefore it is not possible to determine if the intervention failed because subjects had not read the leaflet, they had ignored its messages, or the messages were inappropriate. However, unsolicited distribution of leaflets is a common practice.

Randomised controlled trials provide the most compelling evidence of effectiveness. We have found no other randomised controlled trials of the effectiveness of health education leaflets in the prevention of sunburn and few trials of health education leaflets in other settings.⁷ Although leaflets are perceived as low cost and unlikely to cause harm, there are substantial opportunity costs associated with promoting strategies

of unproved effectiveness. We commend the more extensive use of randomised controlled trials in the evaluation of primary prevention programmes.

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Prevalence of urinary and faecal incontinence in hospitals and residential and nursing homes for older people

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Studies of older people in long term care have shown that urinary and faecal incontinence are more prevalent in this group than among older people in the community.¹⁻³ However, data describing the size of the problem in all types of long term care are lacking. We determined the prevalence of incontinence to assess the use of aids among older people in long term care.

Subjects, methods, and results

In November 1990 a census of all people aged 65 years and over in long term care was carried out in Leicestershire.⁴ Data were collected on health, dependency, and the use of continence aids. Residents experiencing at least one incontinent episode weekly were defined as being incontinent of urine or faeces. Physical dependency was determined by a modified dependency measure used previously in Leicestershire.⁵ An additive score was derived from ratings of mobility (four point scale of 0-3), washing/dressing

(three point scale of 0-2), and feeding (three point scale of 0-2), with higher scores indicating greater dependency. Our measure of physical dependency excluded ratings for urinary and faecal incontinence since these were the variables of interest for comparison. A score of 4 and over was taken to indicate high dependency in line with our modification to the measure devised by Clarke *et al.*⁵

There were 6079 residents in 241 residential or nursing homes and hospitals whose mean age was 82.7 years (SD 7.8; range 65-109 years), and 79% of whom were women. Data for incontinence were recorded for 95% of residents (5758). Forty four per cent were incontinent of urine or faeces, or both (table). The remainder were continent, of whom 7% required prompting and 1% wore a continence pad as a precaution. Incontinence was associated with physical dependency in each type of home (Kruskal-Wallis test, $P < 0.001$). For example, 67% of the incontinent in all homes had high physical dependency compared with only 18% of the fully continent. Forty nine per cent of incontinent people used continence pads or pants, 15% were catheterised, and 36% used no continence pads or pants (table). The use of continence aids among incontinent residents differed significantly between home type (χ^2 , $P < 0.001$).

Comment

The census showed a higher prevalence of urinary incontinence in residents of homes than among older

Prevalence of incontinence and high dependency and use of continence aids in residential and nursing homes and hospitals in Leicestershire in 1990. Values are percentages

	Type of establishment (population and size)								Total (n=5758)
	NHS acute (n=627)	NHS geriatric (n=446)	NHS psychogeriatric (n=397)	Local authority (n=1704)	Private residential (n=1244)	Private nursing (n=946)	Voluntary sector (n=192)	Other hospitals and hostels (n=202)	
Percentage of all patients or residents									
Incontinent of urine	20.7	30.9	28.2	21.3	19.1	29.7	6.3	15.3	22.7
Not catheterised	9.3	22.9	27.0	19.4	16.4	23.5	5.2	11.4	18.4
Catheterised	11.5	8.1	1.3	1.9	2.7	6.2	1.0	4.0	4.3
Incontinent of faeces	4.2	2.7	1.8	2.9	2.9	4.3	0.5	4.5	3.1
Doubly incontinent	9.4	26.5	36.5	13.9	10.2	32.6	4.2	7.9	17.7
Not catheterised	3.7	17.3	34.3	12.8	8.9	25.4	3.1	6.9	14.3
Catheterised	5.7	9.2	2.3	1.1	1.3	7.2	1.0	1.0	3.4
Continent or remains dry with prompting	65.7	39.9	33.5	61.9	67.8	33.4	89.1	72.3	56.5
High dependency	34.7	60.9	47.2	26.3	31.9	70.2	17.0	23.6	39.3
Percentage of incontinent patients or residents									
Use of continence aids:									
Any aid (including catheter)	61.1	74.3	72.5	52.3	64.9	69.4	63.6	58.9	64.1
Pants or pads	17.4	48.7	67.7	45.5	55.6	52.5	51.5	45.2	49.3
Catheter*	43.7	25.7	4.8	6.8	9.4	16.9	12.2	13.7	14.8

*Includes some incontinent residents who also use pants or pads.