Letters

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Rights involve responsibilities for patients

EDITOR—In the United Kingdom every citizen has the right to medical care. No longer limited to palliation, this care has become increasingly curative and even preventive as a result of the increase in knowledge that has accumulated from experience of the conditions that gave rise to its need. Rights, however, do not exist in a void and their exercise involves responsibilities.

In the 2400 years since Hippocrates, it has always been recognised that medicine advances by the sharing of experience and that patients generally have the responsibility to allow their experience to be used for the benefit of others who may subsequently have a similar condition, the confidentiality of their personal characteristics being protected by the professional code of their physicians. Exceptions can always be made in particular cases, but this has been the general rule.

Now, however, according to the advice of the General Medical Council this is no longer to be so; information, it is proposed, may be shared with medical research workers only with the patient's expressed permission. As such permission may not have been sought, this proposal will put serious obstacles in the way of clinical research and will put even more serious obstacles in the way of epidemiological research, particularly if (as with the maintenance of cancer registries) this research requires representative data.

The right to medical care should, we suggest, generally continue to include the responsibility to allow the information gained in its course to be used for the benefit of others who develop a similar disease, or are at risk of developing it. Confidential sharing of information about patients between doctors and bona fide medical research workers (with exceptions only in particular cases) has done no harm and has achieved much good. Why destroy it?

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Advice to authors

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Cancer registries fear collapse

Need for patient consent for cancer registration creates logistical nightmare

EDITOR—The guidance from the General Medical Council saying that patients' consent is required before cancers can be registered will lead to chaos.[1]

The UK Association of Cancer Registries has achieved a remarkable record of cancer incidence and mortality that allows health planning for the future. The registries have found that the most reliable and consistent data on cancers are obtained at the time of diagnosis from histopathology departments.

Diagnosis occurs at an unpredictable time and may often be a surprise to both patient and clinician. To obtain the consent of all patients for registration of the details of their cancer in this situation, and to feed back that information to the pathology department, is unlikely to be possible with a paper based system. The electronic patient record, with a prompt for clinicians and immediate connection to the pathology record, may provide one solution.

Patients must be given clear details of how the information from their clinical episode may be used, and they must have access to that information in order to be assured of its validity. I suggest that there should be a substantial public information campaign to present to the public how cancer registration data can inform healthcare priorities and what the dangers are if these data are lost.

A similar argument can be applied to the Medical Research Council's *Interim Guidelines on the Use of Tissues in Research*,[2] as noted by Furness in his rapid response to Brown's news item.[3] There is also an interesting resonance in the paper by Strobl et al describing the problems with epidemiological research and data protection.[4]

I fully support the rights of patients to make informed decisions about personal data, but the trend exemplified by the guidelines from the General Medical Council and Medical Research Council will hinder the gathering of clinical and research data that will ultimately benefit the whole population. These issues require urgent resolution at a national level.

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1 Brown P. Cancer registries fear imminent collapse. *BMJ* 2000;321:849. (7 October.)
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BUPA wants to ensure systematic transfer of data

EDITOR—Brown warns that Britain's system for monitoring cancer trends could collapse if new guidance from the General Medical Council is implemented.[1] We offer a possible solution to the problem.

The flow of data from the independent healthcare sector into the cancer registries has traditionally been patchy. We have been working to identify a way of ensuring the systematic transfer of data in a way that is legal under the Data Protection Act 1998 and complies with professional codes of behaviour. These codes have evolved to comply with the act, whose influence can be seen in the General Medical Council's booklet *Confidentiality: Protecting and Providing Information*.[2]

At BUPA (a private health insurance scheme) we have agreed the following wording with the Office of the Data Protection Commissioner. We hope that it will appear on paperwork that people sign on becoming members of BUPA's insurance schemes or being treated in BUPA hospitals. The wording forms part of BUPA's data protection notice:

"Research: BUPA supports ethically approved research projects.

- "Anonymised or aggregated data may be used by BUPA, or disclosed to others, for research or statistical purposes. No individual is identifiable in this anonymised research.
- "BUPA supports the assessment of clinical governance. As part of these initiatives the long term effectiveness of certain treatments is measured. To assist in these reviews, named data may be used by BUPA or disclosed to researchers of organisations such as the National Institute for Clinical Excellence (NICE), the Cancer Registry, or the Public Health Laboratory Service involved in such research and will be used only for the specific purposes of the research. Such researchers will be under a duty of medical confidentiality and that imposed by the Data Protection Act.

"Please tick here if you do not consent to this disclosure."

This approach has been shared within our sector through the confidentiality working group of the Independent Hospitals Association. At BUPA we have delayed implementing this system in the hope that some or all cancers might be made notifiable diseases; this possibility was suggested some months ago. We have also heard that the data protection commissioner may say that cancer registration does not require identifiable data.

We would emphasise BUPA's support for the continued use of fully identifiable information. This is clearly essential both to avoid double counting and to allow long term follow up, including linking to data from death certificates.

Cancer statistics in the United Kingdom surpass those of most of the rest of Europe[3]; it would be a retrograde step for this information resource to be dismantled.

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2 General Medical Council. *Confidentiality: protecting and providing information.* London: GMC, 2000.
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Using internet to access confidential patient records

Information about NHSnet was incorrect

EDITOR—I am extremely concerned that an article as out of date as Chadwick et al's was published by the *BMJ*.[1] The editorial panel of the *BMJ* is clearly unaware of important and well publicised developments in information technology that have taken place over the past year and a quarter.

The information in Chadwick et al's article about NHSnet is incorrect in almost all respects. General practitioners do not have to pay either to connect to or use NHSnet, and uptake is increasing rapidly. By 1 October 2000, 70% of practices in England had an ISDN line (a telephone line giving high speed internet access) installed that connected them to the network; many of these practices are actively using NHSnet for email, clinical messaging, and browsing. Two thousand practices have connected recently. All general practitioners need to do before connecting to NHSnet is to agree to comply with a code of connection, which is designed to promote and ensure secure system management.

Users of NHSnet now have guaranteed levels of service that exceed the standards offered by commercial internet service providers, and internet gateways enable users to access the world wide web. The issue is not "can patient access to information be supported by the network?" (which it can) but the more complex clinical and ethical concerns about what information should be made available, in what form, and to whom. This fundamental issue is nothing to do with NHSnet as such.

NHSnet is more secure than the internet and is backed by more service guarantees, including message delivery times and message receipts. New national address books will be on line soon. Layered on the network is the capability to support strong authentication for remote access and strong encryption, and an interim public key infrastructure messaging solution is being implemented as part of the pathology test results messaging project.

Further information about NHSnet can be found on the NHS Information Authority's website (www.nhsia.nhs.uk).

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1 Chadwick DW, Crook PJ, Young AJ, McDowell DM, Dornan TL, New JP. Using the internet to access confidential patient records: a case study. *BMJ* 2000;321:612-4. (9 September.)

Reply from then editor of Information in Practice section

EDITOR—The delay between submission and publication of this paper was plainly too long, and in some details it has been overtaken by events. Just as the NHS struggles to bring some of its systems into the digital era, so does the *BMJ*.

The problem with the Information in Practice section of the journal is that it is monthly, and the small volume of submissions it has received has meant that the editorial committees to consider material for the section are convened every six weeks. Chadwick et al's paper was further delayed by our editorial request that the paper be revised to clarify public key encryption for a general medical audience and then queued for a space in the journal.

Plainly it would have been better to publish the paper much faster. We have conducted an internal review to learn from the incident and have circulated proposals to ensure prompter consideration of papers for the section. Despite this, we defend its publication: in a real life clinical setting its authors showed a competent alternative approach to the corporate network model on which NHSnet is based, as well as providing a useful lesson in how public key encryption might be used to secure clinical systems.

Many of the rapid responses on the *BMJ*'s website were critical,[1] but the paper taken together with this post-publication peer review still gives a valuable lesson for clinicians and managers who wish to understand the issues behind setting up such a system.

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1 Electronic responses. Information in practice. Using the internet to access confidential patient records: a case study. bmj.com 2000;321. www.bmj.com/cgi/content/full/321/7261/612#responses (accessed 18 Jan 2001).

Undertreatment of heart failure has high cost to patients

EDITOR—Chronic heart failure remains a serious public health problem. The diagnosis constitutes a high risk of morbidity and mortality, with a prognosis that is at least as bad as many forms of cancer. Despite this, a high proportion of people with symptoms and signs of chronic heart failure are undiagnosed, and of those who are, many are undertreated.[1] The evidence in support of treatment with angiotensin converting enzyme inhibitors, β blockers, and, most recently, spironolactone, is compelling.[2] It follows, therefore, that undertreatment of chronic heart failure is associated with an increased risk of death, and the failure of the health service effectively to manage this problem costs these patients dearly.

Mason et al analysed individual patient data from studies of left ventricular dysfunction to identify complications during test dose and titration phases.[3] They concluded that angiotensin converting enzyme inhibitors could be safely introduced in primary care, with the proviso that patients at risk of adverse events—for example, patients with severe (New York Heart Association class IV) heart failure—be referred for hospital based initiation of treatment. We support the conclusions reached by Mason et al but wish to draw attention to several additional points. β Blockers and spironolactone offer additional benefits, over and above those of angiotensin converting enzyme inhibitors, yet the rates of prescription of β blockers and spironolactone are even lower than those of angiotensin converting enzyme inhibitors.[4] The evidence in support of β blockers and spironolactone, although comparatively recent, has nevertheless been available for more than a year.[4] The initiation of β blockers and spironolactone in chronic heart failure requires assiduous care. The management of patients with chronic heart failure in the community therefore remains difficult. We investigated one possible solution to this in a ran-

domised, controlled trial of a community based intervention programme led by a nurse specialising in chronic heart failure compared with usual care.[5] In this study, nurse intervention included home visits, checking drug treatments and blood chemistry, and liaising with general practitioners and hospital based physicians. Nurse led intervention reduced hospital admissions and improved compliance compared with standard care. A similar programme has now been instituted in greater Glasgow.

All patients with a new diagnosis of chronic heart failure should, in the first instance, be referred for specialist outpatient care, in keeping with current management guidelines.[1] Intervention programmes led by specialist nurses may be one additional mechanism for optimising the further management of these patients in the community.

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Menorrhagia

Underlying bleeding disorders need to be ruled out

EDITOR—We read with interest the first in your series of articles on common problems in primary care, on the topic of management of menorrhagia.[1] We would, however, like to draw attention to one important aspect that was overlooked, which we believe deserves wider recognition.

Menorrhagia may be a manifestation of an underlying inherited disorder of coagulation. Such disorders are by no means rare. A recent British study found that as many of 17% of women with menorrhagia and no underlying pelvic disease had an inherited bleeding disorder, the most common of which was von Willebrand's disorder.[2] An earlier study from Sweden also found the prevalence of von Willebrand's disorder among women with menorrhagia to be 20%.[3] The history in the initial consultation should therefore include specific questions to elicit features suggestive of an underlying bleeding disorder. These include a history of menorrhagia since menarche, recurrent epistaxis, bleeding after dental extraction, operations, or parturition, and a family history. The Royal College of Obstetricians and Gynaecologists in the United Kingdom has recommended screening of selected women for bleeding disorders in their guidelines on the management of menorrhagia in secondary care.[4] The identification of inherited bleeding disorders is important not only because these women may have invasive procedures but also for future pregnancies and family members. Women with inherited bleeding disorders may, however, not complain of menorrhagia (which is often socially limiting) because their bleeding is similar to what other family members have experienced. The primary care physician is in the unique position of identifying these patients when they attend for other problems. Referral of patients with suggestive histories to a haematologist should be considered.

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1 Hope S. 10-minute consultation. Menorrhagia. *BMJ* 2000; 321:935. (14 October.)
2 Kadir R, Economides D, Sabin C, Owens D, Lee C. Frequency of inherited bleeding disorders in women with menorrhagia. *Lancet* 1998;351:485-9.
3 Edlund M, Blomback M, von Schoultz B, Andersson O. On the value of menorrhagia as a predictor for coagulation disorders. *Am J Hematol* 1996;53:234-8.
4 Royal College of Obstetricians and Gynaecologists. *Management of menorrhagia in secondary care—evidence based guidelines*. London: RCOG Press, 1999.

Sexual history needs to be taken

EDITOR—Hope in her article offers an interesting and logical approach to a common problem.[1] The need for brevity in 10 minutes should, however, not omit a crucial set of questions—namely, an abbreviated sexual history. Assuming a woman is grumpy because of the blood loss may miss a marital separation and consequent risk of introducing a sexually transmitted infection into the equation. Chlamydial endometritis can be associated with severe menstrual irregularity and will not be diagnosed unless thought of and tested for. This is particularly important to do if, as suggested in the latter part of the article, an intrauterine device is to be offered. Just because the patient is older than 30 and married with children should not mean we miss out on some crucial questions—and antibiotics may sort out the menorrhagia from chlamydia without the need for hormones.

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Ten minutes may not be enough

EDITOR—Hope has produced an excellent resume of the territory to be covered when dealing with a patient with menorrhagia,[1] but I am full of admiration for her if she can really achieve all this in 10 minutes (take a full history, examine the patient including a smear, take blood, counsel the patient about options, and agree a management plan).

I could not deliver all this to the patient in 10 minutes flat, even if she took no active part in the consultation. This is a perfect example of the sort of complex consultation that general practitioners encounter these days when patients (quite rightly) want to express their own opinions, show us internet printouts, and even ask questions. The emphasis in general practitioners' training on sharing understanding and decision making with the patient is, in my view, correct.

But few consultations are as "pure" as the one described by Hope. Many patients, particularly older ones, take time to convey their concerns and assimilate the content of the consultation—even dressing and undressing can take almost 10 minutes. We have a choice of believing that patient centred consultations are what patients want (which must mean longer consultations and smaller list sizes) or accepting that we will have to run late or cut some uncomfortable corners.

What next for your 10-minute consultation series? Ten-minute palliative care? Ten-minute dementia? Ten-minute depression? Ten-minute anaemia? The alternative would be to extend the consultation, or manage our time by arranging for the patient to come back to complete all the tasks. But that would not really be a 10-minute consultation. Good idea, good first article. But I strongly urge you to consider renaming this series. "The 20-minute consultation" might just cover it on a good day.

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1 Hope S. 10-minute consultation. Menorrhagia. *BMJ* 2000; 321:935. (14 October.)

Postoperative pressure sores after epidural anaesthesia

Good nursing care should prevent pressure sores

EDITOR—Shah reported three cases of heel ulcers related to pressure after epidural analgesia.[1] A Medline search on the occurrence of pressure sores after epidural anaesthesia shows that, together with the cases reported by Shah, so far only 10 cases of heel ulcers have been reported in the literature.[2–5] There are also two reports on seven patients developing decubitus ulceration after epidural analgesia administered during labour, in whom prolonged sitting and disinfectant pooling under and irritating the perineal skin could have been contributing factors.

The reported concentration of bupivacaine in the postoperative continuous epidural infusion varied from 0.1% to 0.25%, the infusion rate from 6 ml/h to 10 ml/h. Patient controlled epidural analgesia with a

background infusion of 2 ml/h and a demand dose of 2 ml of 0.11% bupivacaine together with adrenaline (epinephrine), sufentanil, and clonidine was reported in three cases.[3] In the report by Shah the infusion rate of 0.15% bupivacaine is missing. The most prominent finding is the occurrence of a motor block on the first day after the operation in two patients.

So far in our hospital we have no documented cases of postoperative pressure sores related to epidural anaesthesia. In 1999, 608 patients received patient controlled epidural analgesia, mostly after orthopaedic (41%), gynaecological (20%), urological (16%), and thoracic or abdominal surgery (13%). Of 252 patients undergoing orthopaedic surgery, 69% had combined spinal epidural anaesthesia and 31% general combined with epidural anaesthesia. Patient controlled epidural analgesia with 0.0625% bupivacaine, 2 μg/ml fentanyl, and 2 μg/ml adrenaline (epinephrine) is administered as a continuous infusion of 6-8 ml/h and a demand dose of 3-4 ml (lockout time 30 minutes). The goal is to obtain sufficient analgesia without motor and profound sensory block, and any motor block should be limited to the immediate postoperative period. Patients may leave the postanaesthesia care unit only after resolution of the motor block, especially after combined spinal epidural anaesthesia. On the ward the neurological status of the epidural analgesia in patients is monitored round the clock by an anaesthesiology pain service. In cases of insufficient analgesia, the anaesthesist can adjust the dose of patient controlled epidural analgesia, administer an additional bolus of 0.125% bupivacaine, or add systemic analgesics.

We agree with Shah that profound sensory and motor block should be avoided, and in cases of prolonged motor block, patients should be treated as paraplegics. But we do not recommend the routine use of heel pads. In general, we believe that good nursing care should prevent pressure sores.

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1 Shah JL. Postoperative pressure sores after epidural anaesthesia. *BMJ* 2000;321:941-2. (14 October.)
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Informed nursing care is needed

EDITOR—The lesson of the week by Shah will increase awareness of the complications of epidural analgesia, but he raises some important aspects only briefly and does not identify others.[1] His three patients received epidural infusions for two to three days. I would question the indication for such prolonged administration in relatively young, healthy patients undergoing surgery below the umbilicus. The ratio of benefit to risk is poor, and complications always seem more likely when that is the case. Epidural block would have been justifiable during the first night after the operation, but thereafter a change to systemic treatment (for example, patient controlled intravenous morphine) would have been more appropriate in terms of the likely severity of pain, the need for medical or nursing supervision, and the ease of patient mobilisation.

Lower limb paralysis in a patient receiving an epidural infusion must lead to urgent assessment and correction. Usually, the cause will be excessive drug administration, but this has its side effects, as Shah's report shows. Paralysis may, however, rarely, be due to a more significant complication such as intrathecal migration of the epidural catheter or the development of a vertebral canal haematoma. Both must be treated rapidly to prevent serious harm.

Block of lower limb nerves can be minimised by placing the epidural catheter at the appropriate level in the vertebral canal. As Shah concludes, at least two of his patients should have had low thoracic, not lumbar, catheter placement so that the maximum drug concentration occurred in the nerves that supply the abdomen. The infusion should have been adjusted to ensure that only those nerves were affected.

Such an approach will minimise the risk of pressure sores, but informed nursing care is still needed. Patients should be instructed to move their legs regularly and report if this is not possible. It is not necessary to nurse patients receiving epidural analgesia on large cell, ripple type mattresses. Simpler measures will prevent sores, identify other complications at an early stage, provide a more mobile patient, and leave resources available for other aspects of patient care. Epidural block is a superb method of pain relief, but it must be implemented and managed to minimise the risks as well as to optimise the benefits.

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Anaesthetists and their teams should examine heels of patients

EDITOR—Shah in his article highlighted the problem of heel pressure sores associated with the use of postoperative epidural anaesthesia in fit gynaecology patients after surgery.[1] This is a problem we have been aware of in our hospital for some time, and I tried to raise awareness of it by presenting a poster at the Pain Society National Conference in Edinburgh in April 1999.

Initially, most of our patients' heel sores were not diagnosed while in hospital but were reported to us by community and stoma nurses. Our patients are mainly general surgical patients, but they do share the problem of not being regarded as at high risk for development of pressure sores by established pressure sore risk assessment tools. The epidurals used in our patients are thoracic rather than lumbar. A possible factor in the missed diagnosis of these patients is the ubiquitous use of elastic compression stockings, which are not removed until discharge and effectively hide the damaged area.

It is not our experience that these sores are associated with dense motor blockade; a profound motor block is regarded as a danger sign and immediately reported to the acute pain team, which will investigate and manage this degree of motor block. Ability to raise the leg has been documented on our observation chart for the past three years. It seems that the desired goal of relief of postoperative pain will cause sufficient analgesia in the upper sacral nerve distribution to stop a normal conscious, well nourished patients' response to incipient tissue anoxia—namely, moving their legs. Our latest strategy to minimise the risk of heel pressure sores is to simply warn patients of the risk and advise them to remember regularly to lift their legs.

One reason for taking action against this problem is that it is so prevalent. A recent audit we undertook across two hospitals in our region showed the incidence to be around 23% of patients who had an epidural for postoperative pain relief. Colleagues who had previously seen this as a nursing problem now all warn the patients of this risk before they place an epidural for postoperative use.

Anaesthetists and their acute pain teams should examine the heels of their patients with postoperative epidurals and not rely on the ward nurses' documentation of pressure sores as most of these sores are missed. I would also be interested to know if the two hospitals we looked at are unique, or if there are many patients in the community who are suffering from heel pressure sores related to the postoperative use of epidural analgesia.

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Staff needs to recognise patients are at risk

EDITOR—I read with interest the article by Shah regarding the development of pressure sores following epidural anaesthesia in patients with no predisposing risk factors.[1] From December 1999 to May 2000 our local maternity unit documented postpartum pressure sores on the buttocks in nine healthy women (mean age 29 years). Six women were primigravidas, two women had had one previous delivery, and for one woman it was her fourth delivery. The mean duration of labour was 11 hours 34 minutes. Epidural analgesia was used in each delivery and lasted for a mean of six hours 35 minutes, slightly longer than the hospital average of four hours. In four of the patients

dense sacral block was induced for instrumental delivery. One woman underwent emergency caesarean section. No risk assessment for pressure ulceration was performed before delivery.

As the cases described by Shah, none of these women had additional predisposing risk factors for pressure ulceration. In some circumstances, however, this type of injury can occur in fit, healthy people. Labour confers many risk factors for pressure ulceration. The positions adopted often increase load and shearing forces over bony prominences, moisture across the sacrum develops from a combination of blood, liquor, and sweat, and forces of friction can occur when buttocks are shuffled across bedding rather than lifted. These risk factors are further increased by the use of epidural analgesia, as sensory block reduces the desire to move whereas motor block makes moving more difficult. Modern epidural techniques aim to give maximal sensory block with minimal motor blockade. This may not be effective in the prevention of ulceration, however; work in patients with spinal injury has shown sensory loss to be a more important risk factor in the development of pressure ulceration than paralysis.[2] Although obstetric epidurals aim to provide maximal sensory block around T9 and T10, in practice extension to sacrum and lower limbs occurs regularly (documented in two of our patients) and is induced to allow instrumental delivery.

In the past 16 months there has been increasing interest in the risk of ulceration associated with epidural analgesia in the obstetric population.[3] The most valuable step in the prevention of these debilitating lesions is an increased recognition on the part of midwives and obstetric and anaesthetic staff that their patients are at risk.

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Limits to demand for health care

Rationing is needed in a national health service

Editor—At the inception of the NHS its proponents asserted that, after the backlog of unmet need was met by the new service, demand would plateau in the 1950s. Instead demand grew rapidly and the cost containment crisis led to a royal commission and the financial stringency with which we are familiar. Now Frankel et al, the optimists in Bristol, are repeating the mistakes of the architects of the NHS in believing that demand is finite.[1]

Can everything that results in some clinical benefit, and that patients want, be funded? Frankel et al's positive answer is based on studies that use expert opinion and research evidence to compare need and want for two elective procedures with the resources available. This ignores the fact that these criteria are themselves rationing devices that implicitly include notions of what is sufficient benefit. The authors provide estimates of demand given certain treatment (or rationing) criteria and argue that if demand, so defined, can be met then it is finite and requires no rationing. This reduces, absurdly, to "if you ration care using our criteria you don't need to ration care."

Treatment criteria are never static; technology changes, and what constitutes need and wants is socially determined—hence the huge variations in indications for elective procedures between the United States and United Kingdom.[2 3] New technologies do not automatically increase costs; they may do so if no intervention existed before (for example, interferon beta for multiple sclerosis and drugs for Alzheimer's disease) or if they lower the threshold (or extend the indications) for treatment. Even if technologies lower unit costs the increased numbers now eligible for treatment can lead to a disproportionate increase in the volume of activity and total spend. For example, the introduction of laparoscopic cholecystectomy resulted in an 11% overall increase in costs in the United States.[4] Health insurance reduces the immediate cost implications of clinical decisions for patients and their agents (doctors), resulting in "supplier induced demand"[5] and hence the need for controls.

Frankel et al ignore the opportunity costs of healthcare expenditure. If a healthcare investment could further increase welfare, the same money, invested in another social programme or in education, might generate even greater benefits. Thus, even if all defined demand could be met, it might not be in society's interests to meet it. This is why economists argue for rationing criteria based on cost effectiveness and not just clinical effectiveness.

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Gap between demand for services and cost of providing them should certainly be assessed

Editor—As Frankel at al note at the start of their article, the notion that demand in the NHS would always outstrip supply has a long history.[1] Roberts had an especially important role in the generation of this fallacy when he warned that the NHS would drain the national economy to such an extent that "the welfare state will surely end in the totalitarian state."[2]

The fallacy was eventually laid bare by the researches of Abel-Smith and Titmuss.[3] Their classic of economic analysis decisively discredited scaremongering concerning the escalating cost of the NHS. Among other things they estimated that the rising costs of the NHS consequent on ageing would be modest (they calculated a rise of 3.5% between 1951 and 1972) and easily contained. But the damage had been done. Soon, owing to the influence of alarmist tracts such as Powell's *Medicine and Politics*,[4] the NHS became habitually characterised as fostering an "infinity of demand" and thereby as a bottomless pit for resources. Over the years this false construction became accepted as dogma by politicians and even members of the medical and allied professions.

These unsupportable and inappropriate catchphrases, by their implication of ultimate hopelessness, have done substantial damage to planning and morale in the health service, as well as being detrimental to the NHS's reputation abroad. What has been needed for decades is careful analysis of the extent of the gap between demand for medical services and the cost of providing them, and how this varies with time and place in different branches of the NHS. We therefore welcome Frankel et al's statement that "The proposition that the limits to demand lie within the capacity of a properly resourced NHS should be tested explicitly."

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Article contained several fallacies

Editor—Frankel et al's article on the limits to demand for health care argues that the potential demand is neither infinite nor essentially incapable of being satisfied.[1] The debate about rationing health care is therefore led by a mistaken ideology fed by economists' pessimistic view of life as a continuing struggle to deal with scarcity.

The article contains a series of fallacies. The first is the "but we've put a man on the moon" fallacy. This argument is trotted out whenever a seemingly simple idea cannot be implemented. The National Aeronautics

and Space Administration (NASA) put a man on the moon simply because that was the one goal it was set, and billions were poured into the project. No one has told the NHS that its one objective is to abolish waiting for the small list of operations that Frankel et al choose.

Then there is the "if each of us did a little bit more" argument. It looks appealing but breaks down on examination. If each of us saved just £1 a day we could, as a nation of 55 million people, wipe out developing countries' debt in a few years. The key word in that sentence is the first. Linked to this is the notion that surgeons do operations. From a systems point of view they are merely a part, albeit an important one, of a system that allows patients to have safe operations.

Next there is what I call the "Nye Bevan" fallacy. This is the notion that healthcare practices are static and that we can, over time, find the money to meet every demand. The ever increasing drive to innovate (older as well as younger patients being considered suitable for hip replacement; new methods of thromboprophylaxis, gene therapy, and microsurgery being developed) means that potential aggregate demand for health care will always outstrip resources.

Finally, uniquely in health care we believe that inequality is bad. We tolerate it in education, economic wellbeing, social environment, housing, employment, and transport. In none of these do we have the same problem of resources and demand being out of kilter for the simple reason that we allow the market to operate, with only marginal social intervention to look after the desperately needy. In health care we have rightly denied ourselves that option. We can resolve the resulting dilemma by overt, politically led, rationing[2] or by arbitrarily restricting access (waiting lists) or by tolerating poor quality.[3]

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Authors' reply

EDITOR—Now that substantial investment in the NHS is occurring, the claim is becoming more common that "rationing" is simply a neutral gloss for making sensible choices. This is completely unconvincing. The association between rationing and denial was deliberately evoked by those who coined this term: when did we hear lottery winners asked how they would ration their winnings? Those promoting rationing "adopted this term because it provokes the greatest public controversy."[1] The tendency to evacuate the distinctive meaning of the term rationing is apparent in Maynard and Sheldon's treatment of the provision of elective surgery. If people are exposed to the risks of surgery only when the benefits outweigh the likely harm, this is protection rather than rationing. The fallacy that public provision must fail to satisfy demand was always, and continues to be, more political than empirical, as Loudon and Webster authoritatively point out. Rao's concern with rationing for equity is dealt with elsewhere.[2]

An interesting instance of the difficulty that otherwise informed people have with questioning the assumption that supply cannot meet demand came from the editorial committee of the *BMJ*. An epidemiological paper that implied that rationing of primary total hip replacement was unnecessary[3] was rejected by the *BMJ* on policy rather than scientific grounds: "We remain unconvinced by the argument about the lack of need for rationing [of total hip replacement] … You say … that an increased provision of 50% over a 5 year period would clear the backlog. But where is this increase to come from and so how is rationing to be avoided?"(rejection letter, 10 June 1998). The answers to these questions, which were not sought as the correspondence was firmly closed, is, first, one additional operation every three weeks by each consultant orthopaedic surgeon, and, second, from funds that have since been allocated. The *BMJ*'s editorial committee could not conceive of the eventuality of a soluble problem and so was unwilling to publish a paper that might have pointed towards that solution.

The rationing debate has been almost unencumbered by the conventions of empirical inquiry, but one has to have passed through an intellectual hall of mirrors to be able to assert that "rationing will be good for our health."[4] Attempting to provide better coverage of unequivocally beneficial remedies would presumably be even better for our health, if, as seems likely, the barriers to doing so are based more on prejudice than evidence.

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bmj.com A longer version of this letter is available on bmj.com

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NHS needs plan for all acute, rehabilitative, and long stay care

EDITOR—Everyone sees the world from where he or she stands. Seeing the NHS through American eyes, Leatherman and Blackman believe that the service has fundamentally "got it right."[1] Yet, fundamentally, the NHS no longer exists, for the 1990 Community Care Act changed the legislation in 1948 that underpinned it.

The NHS, operational research, and rehabilitation were three healthcare legacies of the second world war.[2] The operational plan that underpinned the NHS transferred wards full of bedbound patients to hospital care from local government care. From that unlikely beginning the specialty of geriatrics began.[3] If the hospital responsibility for providing a free long stay service is taken away then the driving, rehabilitative force that underpinned the NHS ceases to exist.

During the Thatcher years a cruel trick was played on pensioners, as well as on entrepreneurs. Using the rhetoric of markets, choice, and quality, the government transferred responsibility for long stay care for sick and disabled people from the hospitals to the private and voluntary sectors. Thousands of hospital beds were closed; consultants in geriatric medicine took on general medical duties; general physicians became specialist physicians; waiting lists disappeared; everyone was happy—except, that is, pensioners paying for their own care.

In April 1993 the government closed the open door. Now, we have the worst of all deals. The NHS no longer exists; pensioners are being told that they should insure for their long term care; nursing is being redefined to exclude personal care (washing, dressing, feeding, toileting); waiting lists are growing; acute hospital beds are full; and the whole pack of cards is collapsing.

To make matters worse, the generation that fought in the second world war is now in need of care. Yet "new Labour" is moving inexorably away from Beveridge towards a Bismarck model of care for older people[4]; soon, no doubt, everyone will be means tested for long term care. What is needed now, if a long term vision for health and social care in the United Kingdom is to be achieved, is a coherent, equitable, and efficient plan for all citizens' acute, rehabilitative and long stay care.

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Driving after hernia surgery

Patients should be advised not to drive for 10 days

EDITOR—Amid in his editorial and Ismail et al in their short report say that surgeons traditionally advise patients recovering from groin hernias not to drive for a month or two and recommend national guidelines be

developed.[1 2] In 1976 we published the effects of surgical operation on the "brake clutch simulator"[3] and showed that patients who had an inguinal hernia repair under general anaesthetic were able to perform an emergency stop in exactly the same time as they could preoperatively eight days after operation.

In an average car braking system, in 1975, a pedal force of 600 lb per square inch would produce an emergency stop of 0.87 g deceleration from 30 mph. The brake clutch simulator consisted of an adjustable car seat with pedals attached via hydraulic links and cylinders to load syringes, together with gauges to monitor the pressure in the brake and clutch lines, and a transducer for pressure recording. Microswitches were provided that standardised the position of the feet at the beginning of the test and indicated when either foot had left the floor. Other switches indicated the start of pedal pressure, and in the case of the clutch when movement was complete. The stimulus to start the whole cycle of simulated emergency stop was provided by a light operated by a button that came on at random intervals.

The effect of general anaesthetic was examined in five patients who had had a minor surgical procedure that did not involve an operation on the trunk or legs 24 hours previously. No adverse effect was found. Also the effects of learning the test were examined in 10 subjects with suitable rest periods in between, and no difference was found.

Twelve men with a right inguinal hernia and 12 men with a left inguinal hernia were studied. All held current driving licences. They were tested preoperatively and on postoperative days two, four, and six, the patient with the left inguinal hernia on day eight, and the patient with the right inguinal hernia on day seven.

The performance in patients with a left inguinal hernia returned to preoperative levels by day eight and those with a right inguinal hernia by day seven. As a result of this work it has always been my view that patients who have had an open inguinal hernia repair under general anaesthetic be advised not to drive their car for 10 days after the operation.

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Claims in editorial from Lichtenstein Hernia Institute are unsubstantiated

Editor—Advice on postoperative driving is important. Ismail et al have identified serious deficiencies in the advice that is given to patients and the application of scientific evidence to this advice.[1] National guidelines on driving after surgery would be welcomed by surgeons, patients, and motor insurers.

The ability to perform an emergency stop is fundamental for safe driving. After hernia surgery, the efficiency with which an emergency stop can be executed is dependent on reaction time and unimpaired, pain free, movement of the lower limbs. Reaction times after laparoscopic and open tension free mesh hernia repair have been measured in a randomised controlled trial.[2] Foot reaction times after open hernia surgery were significantly slower than after laparoscopic hernia surgery. Interestingly, after open hernia surgery hand reaction times were also longer; Wright et al attributed this difference to greater use of opiate analgesia after open hernia surgery.

Significant postoperative groin pain will impair the performance of an emergency stop. The Lichtenstein Institute's claims in the editorial by Amid that the tension free mesh repair is less painful than conventional hernia repair and is as pain free as laparoscopic hernia surgery,[3] have no scientific basis and warrant further investigation.

Two systematic reviews of randomised controlled trials in hernia surgery were recently published in the *British Journal of Surgery*. The first paper compared open tension free mesh repair with conventional open hernia surgery.[4] Over 4000 patients were analysed from fifteen studies. The only significant finding was that the Lichtenstein mesh repair has a lower recurrence rate. The second paper compared laparoscopic inguinal hernia repair with conventional surgery.[5] Thirty four trials were identified, with 6804 participants. Postoperative pain was less in the laparoscopic group ($P = 0.08$) and time to return to usual activity was significantly lower ($P < 0.001$). Nine trials comparing laparoscopic repair with tension free mesh repair assessed analgesia usage. In eight studies statistically significantly less analgesia was used after laparoscopic hernia surgery.

The Lichtenstein repair is an excellent repair in terms of recurrence rates. There is, however, no significant evidence to support the Lichtenstein Institute's other claims for their repair. The evidence suggests that patients should not drive for one week after open hernia repair but could drive earlier after laparoscopic surgery. In both groups it is important to recognise the deleterious effect that opiate analgesia can have.

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Research in complementary medicine is essential

Editor—Nahin and Straus highlight the problems of conducting clinically rigorous research in complementary medicine.[1] They are right, though, to emphasise the need for such research; in an era of evidence based medicine it is difficult to justify deploying resources in the absence of convincing benefit. Complementary treatments have many advocates in palliative medicine, and many hospice services offer, or are under pressure to offer, such treatments. We have reported a pilot study of a randomised prospective study of reflexology (C S K Ross et al, proceedings of the first congress of the research network of the European Association for Palliative Care, Berlin, December 2000).

The rationale for reflexology depends on the "reflection" of organs or body parts on the soles of the feet, which can be palpated to diagnose functional imbalances and correct them. Patients received either reflexology or standard foot massage; a criterion for eligibility for randomisation was that they had not had either treatment before. Both treatments were administered weekly for six weeks by any one of three therapists, who had agreed standardised methods. The therapists could not be blind to the treatment they were administering, but bias was minimised by using different therapists and having the assessments conducted by an independent research nurse, who was unaware of the treatment received.

SUE SHARPLES

Although all patients greatly enjoyed the treatments, there was no discernible difference in outcome between those receiving reflexology and those receiving standard foot massage. The pilot study was small (only 17 patients), but it was clear that large numbers of patients would be required to prove the null hypothesis and we decided not to proceed. The conclusion was that the employment of a reflexologist could not be justified but that nursing staff or volunteers could be trained in the skills of simple foot massage, which was popular with both patients and staff.

In the current climate of suspicion surrounding medical science, we believe it essential to continue to look critically at all candidates for resources. An open mind is a prerequisite to a credible outcome of research in this area, and research design is problematic for the reasons given by Nahin

and Straus. But to allow ourselves to be pressured into supporting the introduction of any treatment, complementary or conventional, that cannot be shown to have the benefits claimed would be an abdication of responsibility.

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Continuity in general practice

Continuity is fine, but not for everything

EDITOR—With reference to the article by Guthrie and Wyke,[1] continuity in general practice is one of those obvious good things, but it is too complicated to be something with an easy answer, an all or nothing. In 1988 I wrote a personal view which proposed that patients might see a different doctor for acute illness than for their long term problems.[2] They might even travel to see this personal doctor. This was met with some amazement by some of my colleagues.

The changes in a society that now expects to be able to get money at midnight and shop in Tesco at 2 am (and I am as guilty as anyone else) means that, in places where general practice demand is high, systems have to be developed to cope. So we have walk in centres, triage systems, or duty doctors seeing all those strange things, social, medical, or just "I'm off work today," that need to be seen now. In quiet places of low demand, general practitioners may disapprove of this development, but this is the only way that current demand can be met in some places.

This is the only type of care that a government can expect if it wants you to see your general practitioner within 48 hours. Continuity in these situations is nice, but is a gold standard that is difficult if not impossible to achieve, perhaps valued more highly by politicians than by doctors or even patients. Non-acute problems that can wait (for example, hypertension, diabetes, and continuing emotional problems) will all benefit from an ongoing relationship and continuity of care—sometimes just from the general practitioner, sometimes from a team. This type of care demands commitment from primary care to ensure that those involved can provide it. Increasingly, general practice is an activity carried out alongside raising children, participation in NHS management meetings, clinical posts in hospital, or just the desire to work fewer hours in the week.

Continuity also demands a culture change in society. I have to plan some weeks ahead to see my dentist, accountant, or solicitor, so patients will have to develop forward planning skills in order to have continuity with their general practitioner for their ongoing problems. Continuity is fine but not for everything. It is impossible in a "must be seen within 48 hours" system, but, at the right time and in the right place, it can continue to be a major strength of which British primary care can be rightly proud. Perhaps my 1988 musings are coming true?

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Continuity of care is not all or nothing

EDITOR—With reference to the article by Guthrie and Wyke,[1] it is important that continuity of care in its original sense continues as a core value for general practice despite the considerable changes of the last 20 years. It is one of the main reasons why our service is both effective and cost effective.[1] The concept, however, that continuity is an all or nothing phenomenon needs to be questioned in view of these changes and the expectations of patients.

Firstly, with increased social mobility, patients can no longer offer continuity to their doctors. We practise in a relatively stable rural community, but only 47% of our current patients were registered 10 years ago and only 23% were registered 20 years ago.

Secondly, patients increasingly exercise their right to make choices. An individual doctor cannot now be available at times that are convenient to all patients. Our experience is that many patients with acute problems would prefer to see any doctor if it can be at a time convenient to themselves. Patients often choose a different doctor on purpose according to the situation—a female doctor for a gynaecological problem, a doctor with manipulation skills for backache.

We have developed the concept of continuity for an episode of care to acknowledge these developments. Patients in our practice are encouraged to see the same doctor over time for a single problem. A diabetic patient may see the same doctor over several years for their diabetic care but a different doctor for a sore throat. An audit showed that 98% of our diabetic patients and 95% of asthmatic patients had their routine checks with their usual doctor. This system does not prevent a patient from seeing the same doctor for all their care when the doctor is available. As ongoing care can be planned in advance, we have found that this system improves the management of our availability of appointments.

Thus we try to ensure the best aspects of traditional continuity of care, but also offer the flexibility demanded of modern practice. One important aspect of this concept is that doctors may not get to know their patients and their families so well. Primary care professionals need to pay more attention to the exploration of a patient's health beliefs and cultural aspects of health in each consultation to ensure the continued effectiveness of general practice. We would welcome research into models such as ours so that they may be refined for the benefit of patients and primary care.

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Hamster health care can be solved with more funding

EDITOR—I must endorse Morrison and Smith's editorial on the widespread problem of time pressure on doctors, with its adverse effects on patient care and professional satisfaction and morale.[1] My geriatrician colleagues and I are especially plagued by time pressures: histories are longer and more difficult to elicit and evaluate in older patients; examinations take more time; prescribing for polypharmacy requires more thought and greater care; and advice to patients or carers must be given slowly and often repeated.

I cannot agree, however, that "organising medical practice in a way … ill suited to an information age and a world of sceptical, better informed patients who … want the best care" is a major underlying issue that should be solved. And it seems unlikely that doctors can "redesign their work to meet their patients' needs within the economic constraints, just as … in … other service industries."

Certainly, all time saving proposals should be explored, such as reduced and streamlined paperwork, easier access to results or consultations, and various new ways to transmit information or contact patients. But an irreducible time will remain for the provision of face to face contact with patients; for reflection, planning, and discussion; and, at times, for further exploration with family members or a consultant.

Morrison and Smith seem hesitant to press for an obvious but costly solution: more doctors and more time with patients. The aetiology of hamster health care is long exposure to austere health budgets. The symptoms may be partially and temporarily ameliorated by various interventions, but the prescription for cure is replacement therapy—that is, adequate funding.

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