Letters

NHS reorganisations: who's kicking whom, who's protesting?

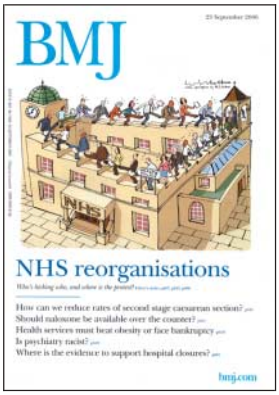
NHS is not short for National Health Service

Editor—Hawkes' description of English healthcare is uncannily accurate: painfully so for those of us that have given much of our time (the best years of our lives?) to supporting the "New NHS"; for which, now read the "Old NHS."[1] He is right to identify the kicking hierarchy as being important.

I have often wondered how it is that we are all so proud of the National Health Service—as we tell people that we meet on our foreign holidays—but that we complain endlessly about the NHS. Are they not the same? I would argue that they are not.

The National Health Service (although invented by a far sighted politician) is a much-loved collaboration between patients, the public, doctors, nurses, and the UK government. Like the British constitution, or a well functioning family, it works without very much being written down. It is immensely powerful—any government that was seen to threaten it would be doomed—but the power exists only because people care for it.

The NHS is an administrative agency of the government that exists to ensure that the money collected by the government for the National Health Service is spent well. Unlike the National Health Service itself, the NHS is prone to being officious, bureaucratic, over-controlling and frequently just a pain. The NHS is meant to be a supporting structure and, at its best, it can do this very well. Even so, the NHS is relatively weak, and trembles at the sight of government ministers—just as government ministers tremble at the sight of the National Health Service.



So here we have the true hierarchy. The National Health Service kicks the government, and the government kicks the NHS. So next time you get an unintelligible letter with the NHS logo on it, remember that it has come from one of your servants.

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1 Hawkes N. Who's kicking who? *BMJ* 2006;333:645-8. (23 September.)

Nothing surprising is happening

Editor—"Something strange is happening in the NHS," complains Godlee.[1] What? Aneurin Bevan promised that the government would fund the health service but leave its operational running to the doctors, and this has not happened. We are witnessing the iron law of political economics in action: "He who pays the piper calls the tune." Nothing surprising is happening in the NHS.

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1 Godlee F. Editor's choice. While Rome burns. *BMJ* 2006;333:0. (23 September.)

Will and power

Editor—Godlee laments the demise of medical professionalism in the NHS and quotes Greener, who wonders whether doctors have lost the will or power to stop reforms of the NHS which some believe to be vandalism.[1 2]

They have certainly lost the power and with it, of course, the will, because politicians have long believed, as accountable guardians of public finance, that they have a duty to cull the influence of the medical profession on healthcare provision. The medical profession was uncontrolled by Bevan, and thereafter proved to be a source of expanding expense. This is due to its ingenuity and the development of new treatments totally unpredicted by the Beveridge report (1942), which believed that national health care would be so good that the need for it would soon diminish.

The loss of consultant power started locally when the "cog-wheel" system was introduced into hospital management in the late 1960s. The consultant dominated "firms" were infiltrated with representation from nursing, general practice, junior staff, and others. The chairmen of these "divisions" sat on "the medical executive committee," which told management to implement the priorities for medical care that it had selected. However, it soon became demoted to the medical advisory committee, but at least democratic representation remained, and its advice was still respected by the district management team of about six members with the ultimate executive power.

In the 1990s the clinical directorate system was introduced; the clinical directors were now appointed by management and were no longer the representatives of their "division" or specialty. They became responsible for implementing management decisions, which gives the impression that the medical staff condoned these decisions, even though they were taken with minimal consultation or even against its advice.

The politicians have an axe to grind: they need re-election, and they perceive that their electorate wants top grade health care, with minimal waiting times and local provision. This government has poured money into the NHS, yet the proportion of the UK gross domestic product put into health is still not much more than 7%. It is 8-10% in France, 10-12% in Germany, and 15% or more in the United States. With such minimal funding, some rationing is inevitable.

What we "anti-reformers" can't escape is knowing that the best bed managers are consultants, ward sisters, and their secretaries. Management consultants do not seem to understand what is involved, and neither do politicians. Unless they can be persuaded to do so, our professional integrity will not be salvaged. But I don't suppose that would bother them.

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1 Godlee F. Editor's choice. While Rome burns. *BMJ* 2006;333:0. (23 September.)
2 Greener I. Where are the medical voices raised in protest? *BMJ* 2006;333:660. (23 September.)

Where are the medical voices raised in protest: fit for the future?

Editor—Greener asks whether the medical profession approves of the government's reforms.[1] We are consultants in acute medicine in West Sussex, a part of the Kent, Surrey, and Sussex Strategic Health Authority, which has recently attracted considerable interest about the possible restructuring of

services. Not least are proposals to reduce the workload from primary care, which we are assured are supported by general practitioners. We conducted a simple survey to gauge the degree to which they thought that the proposed changes made by the previous primary care trust could be instigated.

We sent 130 questionnaires on emergency and elective medical care to all general practitioners registered in the Arun, Adur, and Worthing district; 86 replies were returned (66%), of which two were not completed and one practice of six partners did not comment. This left a sample size of 78 (60%).

Firstly, we asked if a proposed 20% reduction in emergency workload at the acute hospital was achievable without compromising clinical care in emergency general medicine, clinical haematology, cardiology, medical oncology, neurology, rheumatology, and geriatric medicine. Less than 10% thought that a 20% reduction was achievable, and 75% thought that no reductions at all were possible.

Secondly, we asked if a proposed 30% reduction in outpatient workload was achievable in the specialties mentioned above plus gastroenterology, dermatology, respiratory medicine, and nephrology. Again, 85% of the sample thought the proposals unrealistic in the current system. Only 15% thought that a 30% reduction in dermatology outpatient referrals were possible, despite this often being targeted nationally.

Thirdly, we asked if the proposed 8% reduction in intensive care admissions was achievable. No one thought it was.

Fourthly, we asked whether the suggested 57% reduction in accident and emergency admissions was achievable. Only one doctor thought it feasible.

Clearly there is little confidence in the proposals among the general practitioners who will have to manage the referrals under the proposals. Our results show that proposed reductions in secondary care are deemed impossible without unprecedented change detrimental to all.

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We thank our colleagues in West Sussex for taking the time to answer our questions.

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1 Greener I. Where are the medical voices raised in protest? *BMJ* 2006;333:660. (23 September.)

More patient choice with less doctor choice is bad for everybody

Editor—Hawkes provides a clear account of the barrage of politically motivated changes the NHS in England has ever had to endure.[1] This outstanding article cuts through political correctness, pointing out the true motivations for recent government policy—money, power, and control.

The rushed implementation of proposed changes to postgraduate medical education is a particular concern[2] and serves as a pertinent example. One of the five key principles for reforming senior house officer training, originally set out by the chief medical officer in August 2002, was that training should allow for individually tailored or personal programmes.[3] In other words, doctors' choice.

However, Modernising Medical Careers material published 18 September 2006, regarding online application into specialist or general practitioner training states that specialty trainees will be able to apply for two specialty groups and two units of application for each specialty.[4] This reverses the current position of doctor choice and flexibility of specialty and location, to one of inflexible and limited choices—allocation. The prospect of being forced to move at relatively short notice, particularly difficult for those with families, to any location within the four UK countries, in order to work or train in possibly an undesired specialty, reminds doctors who is doing the kicking. Ultimately, poor morale and lack of interest in one's specialty will result in a deterioration of patient care.[5]

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1 Hawkes N. NHS reorganisation: Who's kicking who? *BMJ* 2006;333:645-8. (23 September.)
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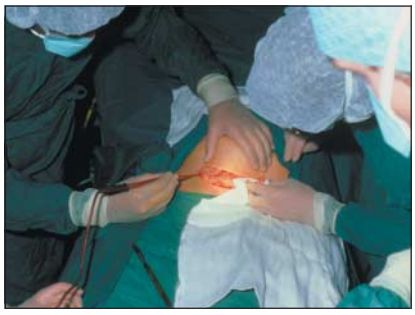
Caesarean delivery in the second stage of labour

Consider the value of a functionally intact perineum

Editor—Spencer et al say that instrumental delivery may reduce the caesarean section rate in the second stage of labour.[1] Although this may be important for the 2006 NHS budget—saving anaesthetic, operating theatre, and hospital costs in the short term—the longer term health outcomes and costs of a high forceps delivery are concerning and go unmentioned.

Recognised third and fourth degree perineal tears occur in 0.5-6% of vaginal deliveries in the western world.[2 3] A further 30-44% are estimated to be unrecognised.[1] One of the most significant factors, clinically and statistically, to be associated with perineal injury is an instrumental delivery.[2 3] Up to a quarter of women with a tear will



JAMES STEVENSON/SPL

experience faecal incontinence.[3] Although perineal injury during childbirth may not be the sole factor for faecal incontinence, perineal damage increases its likelihood.[3] The economic costs of faecal incontinence are large, lifetime cost estimates ranging from £7000 to £43 000, depending on treatment.[4] The social implications are immeasurable. In a questionnaire of their personal birthing choices even female obstetricians chose caesarean section over an instrumentally assisted delivery.[5]

To advocate obstetric management that has been declined by educated colleagues is worrying, particularly when the social and economic costs are so great and the idea of gaining valid informed consent is increasing.

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1 Spencer C, Murphy D, Bewley S. Caesarean delivery in the second stage of labour. *BMJ* 2006;333:613-4. (23 September.)
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Revisit the past

Editor—For me as a general practitioner to respond to the editorial by Spencer et al may seem surprising,[1] but the effects of poorly managed labour spill over into primary care with general practitioners having to pick up the pieces of an exhausted woman having endured a 48 hour labour, a failed forceps delivery, and, finally, a caesarean section.

The focus of the management of labour seems to have shifted from ensuring the outcome of a healthy mother and healthy baby to the more nebulous outcome of a positive or meaningful experience in keeping with the philosophy of patient choice. It is faulty logic to examine outcomes of the second stage of labour in isolation. Each stage requires monitoring and its own set of decisions. In the National Maternity Hospital in Dublin active management of labour set out to describe and manage what these should be.[2] This led to very low caesarean

section rates and low operative delivery. This was recently revisited in a prospective trial of primiparous women, resulting in a section rate of 4.2% and an operative vaginal delivery rate of 24%.[3]

Suboptimal management of labour now seems to be the norm in UK units, with junior doctors not having sufficient training to do the job properly and the process being overseen by midwives who do not adequately monitor or intervene, which leads to the less than perfect outcomes which we now witness.

Perhaps political correctness and the inappropriate exclusion of the medical profession from the management of labour, and indeed the whole of maternity care, have led us to this point. The lessons to be learnt are not just applicable to obstetrics but apply throughout the medical profession.

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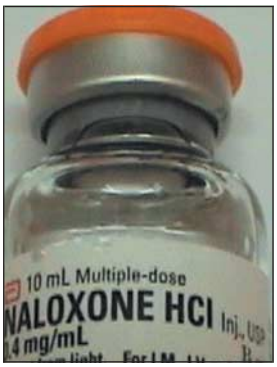
Emergency naloxone for heroin overdose

Over the counter availability needs careful consideration

Editor—In their support for making naloxone freely available, Strang et al state that naloxone saves lives,[1] yet it can also be dangerous, even lethal.[2] Many other reports of adverse reactions are from use in health care, so more harm is likely in the hands of untrained people, especially as some may be intoxicated themselves when the drug is used. This needs to be carefully balanced by the likely benefits and other viable alternatives to address mortality from overdose, given finite budgets and workforce.



Why Strang et al dwell on the wording of existing local prohibitions is unclear. As with injecting centres, a community naloxone trial would require indemnifying legislation. A localised pilot study in a high risk town might use other towns as controls.

Apart from theoretical endorsement on pharmacological grounds, the only reference Strang et al give supporting community naloxone is an unpublished communication (D Bigg, Chicago). There is no indication how adverse events, including deaths, were monitored, or whether there was any misuse of the naloxone—for example, as currency, weapon, etc. Neither are we told of the experience with community naloxone in Italy.

Unlike data on delayed ambulance presentations, experience from medical injecting centres indicates that early overdoses only infrequently require naloxone injection.[3] As with heart and other emergencies, breathing assistance is always recommended for hypoventilation and cyanosis, regardless of the cause.

Strang et al also do not discuss the mode of administration of the naloxone and whether they advise a strict protocol or flexible arrangements.

Methadone treatment substantially reduces the occurrence of overdose. Strang with other colleagues wrote on overdoses and naloxone 10 years ago.[4] To my knowledge, no senior author has yet published a realistic strategy to address the abysmal average quality of methadone prescription in England (average dose under 40 mg, low retention rates, poor supervision).[5]

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1 Strang J, Kelleher M, Best D, Mayet S, Manning V. Emergency naloxone for heroin overdose. *BMJ* 2006;333:614-5. (23 September.)
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Beware of naloxone's other characteristics

Editor—While naloxone is a good drug for resuscitation we should beware its other characteristics.[1] Naloxone has a short half life and so may give unskilled users a false sense of security, introducing a "secondary opiate overdose," particularly when used to treat overdose with a long acting opiate such as methadone. The authors cite 440 "reversals" (an unfortunate misnomer for a competitive antagonist) of 6000 doses distributed: what happened to the other 5560 doses? There is a risk that these were used to avoid calling emergency services as drug users associate emergency ambulance services with police. Or unsuccessful use may have been unreported and some patients died despite attempted inhibition. How many died after "reversal" or required further "reversal"? Furthermore, opiate blocking drugs can provide a useful punishment tool for drug dealers who may use the drug as a method of ensuring compliance with their demands.

In the same issue of the *BMJ* Ian Roberts, an epidemiologist, warns that anecdotal evidence could be highly misleading, citing the use of albumin in resuscitation and steroids in head injury.[2] Richard Lehman opines that in the current political climate it would take considerable optimism to expect that health policy might be governed by evidence alone.[3] Our professional leadership must urgently mark out where the evidence lies.[3] Although it may be reasonable to research the wider availability of naloxone, we need to understand the overall clinical effect, addressing the negative as well as the positive effects of such a change before adding to the illicit drug cocktail available on the street.

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Naloxone is not the only opioid antagonist

Editor—Strang et al say that naloxone is an extraordinarily effective drug, presumably meaning that at adequate doses it always reverses opioid effects.[1] (Incidentally, why does one 400 µg ampoule cost the NHS about £5 when it sells for a small fraction of that in other European countries?) Whether naloxone saves lives in opioid overdose when publicly distributed is, as they recognise, still unproved. Intuitively, it seems worth doing (and monitoring), especially if combined with educating relevant peer groups about airways and resuscitation.

However, naloxone is not the only extraordinarily effective opioid antagonist. Apart from the possible advantages in acute opioid overdose of nalmefene, with its longer half-life, almost complete prevention of opioid overdose and of relapse to heroin for many months after detoxification are now demonstrably possible with long-acting naltrexone implants.[2] Since the authors note that opioid overdose is particularly dangerous in detoxified, non-tolerant addicts, and since naltrexone has negligible organ toxicity, it is equally important (and more evidence based) to extend studies of these implants. Several NHS general practitioners have already observed persuasive outcomes (J Revill, third Stapleford conference, Berlin, March 2006).

Distributing naloxone is also no substitute for raising the quality of agonist prescribing programmes. As Strang himself has previously conceded, NHS doses are among the lowest in Europe. Higher doses are associated with better outcome and

retention and fewer opioid overdose deaths. If the British addiction establishment had not criticised methadone maintenance treatment until the mid-1990s (well after most of western Europe had accepted the evidence) numerous deaths might have been avoided. When for many years, psychosocial interventions were therefore overvalued and methadone maintenance treatment discouraged,[3] is it surprising that many clinicians are still ambivalent about this most evidence based of all treatments for opiate abuse?

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Recredentialling in New Zealand may inform UK recertification

Editor—The authorities in the United Kingdom could learn from the experience of the recredentialling of senior hospital medical staff developed in New Zealand on the basis of a Ministry of Health working party report.[1 2]

Like recertification, recredentialling is repeated every three to five years. Although its primary goal is to ensure patients' safety through examination of the competence of individual doctors, it also focuses on doctors' professional and personal wellbeing and development. These may be tackled in several ways, including further training and improved work conditions—excessive workload, limited work space, and poor equipment may, for example, all diminish the quality of a doctor's work.

Although recredentialling is required by the organisation, the process is owned by senior doctors. The interests of consumers are being recognised through the increasing inclusion of a consumer representative on the recredentialling committees, which are composed of senior doctors from within and outside the organisation. All information received or discussed with individual doctors is confidential and undiscoverable, but the committees' final reports are publicised. These include defining individual doctors' scopes of practice and particular development needs and recommendations to enhance their work through changes in their clinical services and working environments.

Support for credentialling by both senior medical staff and management in this district health board is reflected by the whole or partial achievement of over 83% of recommendations made by credentialling committees. Recredentialling links the rigorous scrutiny of individual doctors' practice to quality improvement by also involving others, including management, to improve their working environments.

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1 Sutherland K, Leatherman S. Does certification improve medical standards? *BMJ* 2006;333:439-41. (26 August.)
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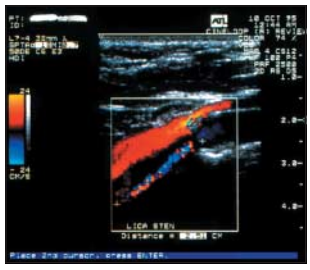
Ageism in services for transient ischaemic attack and stroke

Whose ageism?

Editor—I have misgivings about the paper by Fairhead and Rothwell and about the suggestions of ageism in the accompanying editorial by Young.[1 2] In the introduction, we learn that lower rates of treatment in older people might legitimately reflect patients' choice. However, the conclusions of the abstract assert a willingness to have surgery on the part of elderly patients, and in the discussion section of the main paper we are told that the low rate of endarterectomy in patients of 80 and above is unlikely to have been due to patient choice. Neither of these statements is supported by a reference. In the methods section, we are told that all patients were interviewed and examined so that the potential appropriateness of carotid surgery could be determined. However, we are not told how appropriateness was determined and from whose perspective.

When research findings contradict clinical experience, they demand careful scrutiny. My experience of talking to older people over many years is that many, although certainly not all, begin to lose their enthusiasm for hospital treatment of any sort after the age of 80, let alone for invasive surgery with a risk, albeit small, of harm. In this study the gold standard was a decision made by the patient after discussions with surgeons who were not involved in the study. Ageism is undoubtedly operating in the distribution of healthcare resources in the United Kingdom, but we should not forget that it can also occur when patients are persuaded to accept treatments that do not accord with their own values and aspirations. There is a real danger that locating ageism within rates of prophylactic surgery will distract attention from the much more pervasive expressions of ageism that are to be found in the lack of funding for the care of frail older people in England, and particularly those with dementia.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Competing interests: None declared.

1 Fairhead JF, Rothwell PM. Underinvestigation and undertreatment of carotid disease in elderly patients with transient ischaemic attack and stroke: comparative population based study. *BMJ* 2006;333:525-7. (9 September.)
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Author's reply

Editor—Heath seems to have misunderstood the aims and methods of our study.

Because we were indeed aware that the low rates of treatment of older patients documented in many previous studies might sometimes have been due to patients' choice (as we stated in the introduction), we adopted the new method of comparing a nested, population based cohort, which was investigated exactly as per current clinical guidelines and patient choice, with a larger population based study of routine clinical practice. Using this comparison, we showed that most patients with transient ischaemic attack or stroke who were older than 80 were not fully investigated in routine clinical practice. The low rate of endarterectomy in the older age group was not due to informed choice on the part of patients but underinvestigation by doctors.

When a severe symptomatic carotid stenosis was found most patients in both cohorts opted to have endarterectomy, and this proportion remained high in the over 80s. Heath is right that older people are sometimes anxious about surgery or other hospital treatments. However, our study showed that they are clearly (and sensibly) more concerned to avoid a permanently disabling stroke. There are few things that old people fear more. I followed up all patients after surgery and found no evidence to support Heath's suggestion that surgeons had persuaded patients to accept a treatment that did not accord with their own values and aspirations. Quite the opposite: patients were generally grateful to have been taken seriously despite their age.

Doctors must not use the "well, they probably wouldn't want to be treated anyway" excuse to justify not investigating older patients. In the case of endarterectomy for symptomatic carotid stenosis, good evidence exists that operative risk does not increase with age[1 2] but that the risk of disabling stroke without treatment does.[2 3] Consequently, absolute benefit from surgery increases significantly with age.[2] It is paradoxical, therefore, that some would condone the continuing underinvestigation and undertreatment of the very age group that is at highest risk of disabling stroke and is most likely to benefit from treatment.

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Chelation therapy and autism

EDITOR—More children are being diagnosed as having autism, and there are currently no treatments based on aetiology.[1] Consequently, a number of controversial, unproved, alternative treatments have arisen. The recent death of an autistic child after a medication error with intravenous chelation therapy has brought one purported aetiology based treatment to international attention.[2] The 5 year old child reportedly died from hypocalcaemia after receiving edetate disodium instead of edetate calcium disodium.[3]

Approved uses for chelation therapy include heavy metal poisoning in adults and children, although it has been used in an off-label manner for conditions such as coronary artery disease and Alzheimer's disease.[4] Practitioners are using a variety of chelation agents and routes of administration for children with autism spectrum disorders, with oral dimercaprosuccinic acid, also known as succimer, probably the most common. Several of the agents are not approved for use or are given through an unlicensed route of administration such as rectal or transdermal.[5]

Available information about current use of chelation therapy in autism is scant, and what exists implies that inappropriate agents, routes, or dosage schedules of administration are being used as autism treatments. In addition, there is no compelling evidence to suggest that chelation therapy is an effective treatment for autism. A review of Medline (1966 to April 2006) and Premedline did not yield any relevant reviews or randomised controlled trials of chelation therapy for autism spectrum disorder.

Serious concern should arise about the ongoing use of chelation therapy in children with autism at this time, especially when the side effects of appropriate administration are well reported, a death has occurred with an error of administration, and the treatment incurs a cost for the families. The potential for vulnerable families to seek this as a promised miracle cure raises ethical and professional practice questions that need international consideration.

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Competing interests: None declared.

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Emergency contraception is not just for the morning after

EDITOR—Glasier is right to highlight that emergency hormonal contraception is not the solution to reducing unplanned pregnancy and abortion rates.[1]

However, if we are serious about reducing the rates of unplanned pregnancy and abortion in women of all ages, we need to ensure women can obtain regular contraception easily and in a timely manner. With the current deficits in the NHS, contraceptive services are experiencing a relative disinvestment, forcing many clinics to close or limit the number of clients they see.

Health professionals and the media should also be responsible about how they discuss and report emergency hormonal contraception as some women interpret "the morning after pill" quite literally. They may have the opportunity to get emergency contraception in 48 hours but don't because they think that it is literally for "the morning after."

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Competing interests: None declared.

1 Glasier A. Emergency contraception. *BMJ* 2006;333:560-1. (16 September.)

Poor prescribing is continual

EDITOR—An editorial should bring an important topic to readers' attention and engage their interest, provoke a reaction, and trigger debate. We are delighted that the recent editorial on poor prescribing in the United Kingdom seems to have done all of these things.[1]

We did not give a thorough account of all the evidence, but we are surprised that Rubin thinks that we provided no evidence at all.[2] We cited supporting evidence for our major statements, citations that in turn contain further references to published evidence.

We do not know how much teaching is required to achieve a minimum desirable standard of prescribing proficiency, but we do not believe that reducing the exposure of medical students to experts in the principles and practice of prescribing will produce better prescribers, particularly when drug treatment is becoming increasingly complex. The fact that nurse prescribers are exposed to more than four times the expert teaching that clinical students receive on all forms of practical drug treatment gives us much pause. It is not enough to have the laudable expectations to which Rubin refers—practical measures are needed to achieve them.

Rather than pursuing a debate in the limited amount of space that editorials and letters afford, we have two proposals that might advance the discussion.

Firstly, interested parties should jointly commission an independent systematic review of all the evidence relevant to prescribing and its teaching and assessment for graduates and undergraduates in the United Kingdom and world wide to synthesise current knowledge, identify important gaps, and propose a set of minimum standards. Interested parties would include the General Medical Council, the Postgraduate Medical Education and Training Board, the Audit Commission, the royal colleges, the Council of the Heads of Medical Schools and Deans of UK Faculties of Medicine, the National Patient Safety Agency, the National Prescribing Centre, the British Pharmacological Society, the Royal Pharmaceutical Society, and the Royal College of Nursing.

Secondly, these parties should then hold an open symposium where the problems can be discussed in detail and practical and implementable solutions can be sought and further research proposed.

We look forward to their responses.

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1 Aronson JK, Henderson G, Webb DJ, Rawlins MD. A prescription for better prescribing. *BMJ* 2006;333:459-60. (2 September.)
2 Rubin P. A prescription for better prescribing. *BMJ* 2006;333:601. (16 September.)

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