Fees for completing attendance allowance reports

SIR,—Dr Christopher Law asks how many reports are requested of doctors and why arrangements exist for such reports to be paid for outside NHS remuneration.[1] The answer to the first question is, "All to many!" General practitioners in particular receive a myriad of requests for reports, some of doubtful necessity.

In regard to the second question, there is no doubt that the requirement to pay for these reports on an item of service basis is responsible for preventing even more requests for reports. Moreover, in these days of cross charging between all government departments it would be invidious for general practitioners, who are independent contractors, or indeed hospital doctors, who are salaried to the NHS, to be asked to subsidise a department outside the NHS.

With regard to completion of the report for patients claiming attendance allowance under the new "special rules," the fee agreed with the Department of Social Security takes into account those patients whose records take much longer to examine before the form can be completed.

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1 Law C. Fees for completing attendance allowance reports. *BMJ* 1991;**302**:117. (12 January.)

Role confusion for MAAGs

SIR,—Under current proposals, doctors who join medical audit advisory groups (MAAGs) are local general practitioners who will be selected, paid, and serviced by family health service authorities (FHSAs) to visit practices in the area and check their procedures, records, and development plans. Standards for these have not been agreed but practices may devise their own. Members of MAAGs may report practices that they find fall short of acceptable standards to a local professional committee or to the General Medical Council or the FHSA. MAAGs will provide FHSAs with regular anonymised reports, will provide feedback to practices, will identify areas where help is required, and may carry out commissions of the FHSA or the profession.[1]

Potential members of MAAGs and the practising general practitioners whom they are to visit might have a number of misgivings about these arrangements. The basis of selection of members of MAAGs makes no mention of the standards to which they themselves are expected to adhere in their own practices. Members of MAAGs may be competing for the same limited discretionary funding from FHSAs as the practitioners they visit, and their reports may be suspected of bias for this reason. Members of MAAGs may be expected to visit practitioners whom they already know socially, professionally, or by reputation. This invites bias, or more probably suspicion of bias and consequent ineffectuality. These concerns are particularly problematic in the absence of agreement on acceptable, desirable, and ideal standards for matters which are the subject of audit.

Procedures for ensuring the confidentiality of findings on individual practices have not been publicised. It is realistic to suspect that members of a MAAG serviced and paid for by the FHSA will exchange views informally or formally with servants of the FHSA on the reputability of local practices and the desirability of providing them with discretionary funding. Indeed if MAAGs were well constituted to provide impartial evidence this would be a desirable function.

If current proposals come to fruition members of MAAGs will be subject to considerable role confusion. They will lack defined procedure and the independence required to exercise objectivity. These deficiencies will render their own cost effectiveness highly dubious. The profession's negotiators and potential members of MAAGs should consider these issues before making further commitments.

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1 Irvine D. *Managing for quality in general practice.* London: King's Fund Centre, 1990.

Gulf war casualties

SIR,—Plans are being made for the transfer of British casualties in the Gulf war for treatment in the United Kingdom. We are concerned that this be carried out in the best and most effective way. Several points need to be emphasised.

Transfer of severely wounded soldiers is hazardous, particularly for those requiring intensive care. Burns victims have large and variable fluid requirements. Maintenance of adequate fluid balance will largely prevent the development and morbidity of acute renal failure and will minimise the eventual size of the burns wound. Considerable amounts of fluid are lost in air transfer. In addition, care of the airway and adequate oxygenation are crucial to the outcome and need proper monitoring by experienced attendants.

It would seem vital that adequately trained medical personnel accompany any wounded being transferred to Britain. This implies a full intensive care team or preferably several teams accompanying transfers, depending on the number and the severity of the casualties. Problems arise in civilian life when transferring critically ill patients, underlining the need for adequate medical back up in this exercise.

It is also vital that information is disseminated and coordinated on the treatment of the victims of gas or chemical injuries, in which few units have experience.

We believe that proper attention to the planning and details of transferring the wounded will save lives. We continue to hope and pray that our help will not be needed, but if it is we want our wounded to receive the best possible care.

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SIR,—Drs V S G Murray and G N Volans and Professor David W Yates have written about the probable nature and scale of the war injuries which will need NHS treatment in the coming weeks.[1,2] I am extremely concerned, however, that not even Professor Yates mentioned rehabilitation and that the only reference to non-acute treatment was an oblique one in which he warned that "psychiatric problems may occur" in people recovering from severe burns.

Worst case predictions are that there will be many casualties with severe head injury and complex orthopaedic and neurological injuries including spinal injury. It is essential that regional and district health authorities plan for these patients, whose current rehabilitation in many hospitals leaves much to be desired. Most districts will not therefore be able to cope effectively without specific preparation. Guidelines for treatment and rehabilitation of amputees have been issued by the Disablement Services Authority (14 Russell Square, London WC1) and guidelines for head injury rehabilitation are available through the British Society for Rehabilitation Medicine at the Royal College of Physicians in London.

Military rehabilitation centres are likely to be able to deal with those reasonably certain to return to service duty, but service personnel with more severe injuries may fall to the NHS for rehabilitation. Planners of services in the districts should immediately open discussions with their nearest consultants in rehabilitation medicine and the therapists with whom they work. It would be most unfortunate if the NHS were to lose enthusiasm for the injuries of service personnel as soon as they ceased to excite acute medical or surgical interest. Therapy and support will need to be continued, in many cases for months, and plans must be made now to ensure that appropriately trained rehabilitation teams are available.

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1 Murray VSG, Volans GN. Management of injuries due to chemical weapons. *BMJ* 1991;**302**:129-30. (19 January.)
2 Yates DW. The NHS prepares for war. *BMJ* 1991;**302**:130. (19 January.)

SIR,—This unit is the 600 bedded general and main evacuation hospital for the British forces in the Gulf. We anticipate receiving casualties soon. Our task is to resuscitate them and perform only essential life saving or limb saving surgery, which may not be definitive. After stabilising treatment most casualties will leave us for the United Kingdom, going to either military or civilian hospitals. Because they leave before recovery is complete we will not see the outcome of our successful treatments.

It would be appreciated if a doctor from each civilian hospital receiving military casualties would write to me with the name, number, and rank of any casualties who have passed through this unit, telling us briefly how they are progressing. The knowledge that "Sapper Bloggs is up on crutches" will be sustaining to us here.

Our address is 205 GEN HOSP, BFPO 646. Aerogrammes available free from Post Offices may be sent free if "Gulf forces" is written on the stamp area.

ADRIAN MIDGLEY

205 Gen Hosp RAMC
BFPO 646

Drug Points

Immediate hypersensitivity to aztreonam and imipenem

Drs P HANTSON, B de CONINCK, J L HORN, and P MAHIEU (Cliniques Universitaires St Luc, 1200 Brussels, Belgium) write: Aztreonam has low cross reactivity with IgE antibodies to penicillin.[1,2] We observed an immediate hypersensitivity reaction to the first exposure to aztreonam in a patient who had previously shown hypersensitivity to penicillin.

A 53 year old man was admitted in a coma with meningitis caused by *Streptococcus pneumoniae.* He received penicillin (24 million units daily) and also dexamethasone to prevent cerebral oedema. Other drugs included midazolam, fentanyl, dopamine, insulin, ranitidine, dipyridamole, and heparin. Dexamethasone was stopped on day 6 and the next day he developed a generalised rash. Penicillin was then changed to chloramphenicol. He developed septicaemia related to *Serratia marcescens* on day 29 and was given aztreonam (2 g) intravenously. A generalised urticaria appeared within one hour while he was still receiving 100 mg hydrocortisone daily; no other drug had been introduced. He was given imipenem and cilastatin and again developed an urticarial rash. In both cases the rash cleared up after he was given steroids.