

collapses outside hospital are due to cardiac arrest. In over 80% there is ventricular fibrillation, which carries a high chance of survival given early defibrillation. In practice, it is difficult for even trained rescuers to distinguish between a primary cardiac arrest and a collapse secondary to airway and breathing causes.

In a standardised approach to the immediate resuscitation of a casualty a quick assessment of the airway, breathing, and circulation (which includes opening the airway) should allow the first aider to decide whether the problem is unconsciousness alone, disturbed or absent breathing, or cardiac arrest. If both breathing and pulse are absent and the rescuer is alone the casualty is more likely to survive if the rescuer phones for help before starting cardiopulmonary resuscitation.

It is true that in the first aid world the manual is regarded as a sort of bible. Yet medicine is not a precise science and some treatments recommended, though they benefit most casualties, may occasionally be harmful. The first aid societies stand by their advice and believe that there is sufficient medical evidence to justify their statements in the unlikely event of a "theoretical widow suing a first aider."

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## Effect of NHS reforms on GPs' referral patterns

EDITOR,—Since the advent of the NHS reforms and the internal market, expedient treatment and patients' convenience often seem more important than quality of care. Purchasers who seek prompt treatment for their patients far from home are unlikely to receive the results of peer review audit in the treating unit. Abel-Smith has shown how this may lead to a discredited system.<sup>1</sup> The number of patients being treated far from their local provider unit is unknown, but referral to distant units is promoted by the NHS helpline established by the government.<sup>2</sup>

Although Angela Coulter and Jean Bradlow report no change in referral patterns in 16 general practices studied,<sup>3</sup> we report a case that highlights the problems associated with patients travelling considerable distances for treatment of common conditions. A 64 year old man with bilateral inguinal hernias was seen in a surgical clinic and placed on the waiting list for elective hernia repair. He had had a congenital right inguinal hernia repaired as a child. Because of the length of the local waiting list (waiting time 6-9 months) the patient contacted the NHS helpline, which confirmed that a hospital in south Wales had spare operating capacity.

The patient arrived by train on a Wednesday, was operated on the next morning, and was discharged 24 hours later. Travel back to West Yorkshire entailed a five hour car journey. On arriving home the patient complained of discomfort in the left calf and pain in the left testicle. Over the next five days the testicle became more painful and swollen, and on the seventh postoperative night the patient woke with pleuritic chest pain. He was admitted to the general medical service at Pinderfields General Hospital with a provisional diagnosis of pulmonary embolism. In addition the

left testicle was hard, indurated, and tender. Exploration of the testicle was deferred because of the potentially life threatening medical condition. Doppler ultrasonography suggested infarction of the testicle, and phlebography confirmed venous thrombosis in the left calf.

This case raises concerns about the accuracy of audit data when patients are treated in this way. As the debate about contracting, fundholding, rationing, waiting list initiatives, and the patient's charter rages it is important to document the incidence of complications, which—unlike the primary condition—are often treated in local provider units. Though money may follow the patient, postoperative morbidity tends to stay at home.

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EDITOR,—I am a patient in a London teaching hospital where medical staff have been told not to accept any extracontractual referrals until they have received confirmation that the patient's local health authority will fund that patient. I gather that they have also been told not to worry patients by explaining the real reasons for any consequent delay in treatment.

I consider such an instruction to be wholly misguided. It means that patients, in their ignorance, blame already overstressed medical staff for delays or treatment withheld while those who should be held accountable are cushioned from the consequence of their actions. We patients must be told the unpalatable facts so that we can exert pressure on those who really are responsible for prolonging our pain.

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EDITOR,—In their paper on the effect of the NHS reforms on general practitioners' referral patterns Angela Coulter and Jean Bradlow state that "the overriding impression is that referral patterns remained strikingly similar among both fundholders and non-fundholders."<sup>1</sup> This cannot be left unchallenged. Clearly, the purpose of including a non-fundholding group was to control for variables, including secular trends. The increase in referral rates in the fundholding group (from 107.3 to 111.4 referrals per 1000 patients a year) was much smaller than that seen in the non-fundholding (control) group (from 95.0 to 112.0).

Closer scrutiny of the data sheds further light on this comparative reduction in the referral rates of fundholders. Table IV shows that though for females the referral rate in the non-fundholding group increased from 111.1 to 130.5, the increase in the fundholding group was only from 127.8 to 128.9. For women aged 75 and over fundholders increased referrals by 2.2% whereas non-fundholders increased them by 20.3%. The age specific referral rate for women aged 65-74 decreased by 3.3% in the fundholding group, compared with an increase of 34.5% in the non-fundholding group.

The authors draw attention to the increase in fundholders' referral rates to general surgery (an 8.6% increase), but this should surely be interpreted in the light of the 17.0% increase in such referrals by non-fundholders (table III).

Although brief mention is made of a reduction in general medical referral rates, no attempt is made to compare this 9.8% reduction with the 22.6% increase in the non-fundholders' referral rate to general medicine.

Coulter and Bradlow conclude that "the overall increase in referral rates may seem disappointing to those who hoped that fundholding would provide a mechanism for reducing the demand for specialist care," but our interpretation differs. We suggest that there is considerable evidence in the data that they present for a downward pressure on referral rates, most noticeably in women (perhaps particularly in elderly women) and to the specialty of general medicine. Our only alternative explanation is that the higher referral rates in the fundholding group compared with non-fundholding group in the year before the introduction of fundholding represent an atypical year for these practices.

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- 1 Coulter A, Bradlow J. Effect of NHS reforms on general practitioners' referral patterns. *BMJ* 1993;306:433-7. (13 February.)

## Authors have rights too

EDITOR,—Michael Dewey's plea for authors' rights<sup>1</sup> brought back painful memories, for we have recently suffered the writer's equivalent of torture at the hands of the editors of a journal published by the BMJ Publishing Group. Before drawing our conclusions we summarise the events.

We submitted a manuscript in August 1991 and revised it in October in the light of minor criticisms by the referee(s), whose report was highly supportive. The only request from the editor was that we should reduce the length of the paper. We were therefore taken aback to receive, within two weeks, a highly critical letter from the editor requesting a major restructuring of the paper and enclosing a heavily edited copy of the manuscript. We complied fully with the instructions and re-submitted the paper in January 1992. In February the editor made four new criticisms on technical matters, which we dealt with in a third revision. In May we received another referee's report and a letter from the new editor of the journal. This referee's report asked whether the paper was appropriate for the journal. A fourth revision, taking into account the new referee's technical comments, was submitted in June. The next month we received yet another set of referee's comments and a rejection of the paper on the grounds of its unsuitability for the journal yet complimentary in other respects. Our appeals were rejected.

We were hurt by the insulting tone of some of the written communications and puzzled as to why repeated telephone calls were never returned by the editors. We were dismayed to learn that the new editor was making decisions without access to the full file on our paper.

This series of events wasted thousands of pounds of public funds in terms of opportunity costs; caused embarrassment to us; has long delayed the publication of our work; has reduced the originality of the work as others have published papers on related topics in the intervening period; and has swept away our confidence in the editorial and peer review process. Our sense of injustice has been shared by three senior journal editors we have discussed the matter with.

Our recommendations are as follows:

(1) The decision about a paper's suitability for the journal should be an early one, and no revisions should be requested until this decision has been made.

(2) When revisions are requested there should be a commitment to publish if the criticisms can be met.

(3) New editors and new referees should take into account, and take responsibility for, the views and decisions of their predecessors.

(4) Communication should be respectful and by telephone when appropriate.

On a wider note, authors need to organise themselves to redress the current imbalance of power. In recovering from our torture we take solace from the knowledge that we share with H G Wells, Oscar Wilde, William Butler Yeats, W Somerset Maugham, James Joyce, and many other writers the experience of having had a rotten rejection.<sup>2</sup>

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1 Dewey ME. Authors have rights too. *BMJ* 1993;306:318-20. (30 January.)

2 Bernard A, ed. *Rotten rejections. The letters that publishers wish they'd never sent.* London: Robson, 1991.

EDITOR.—Michael E Dewey raises an important point regarding the standards used by journal editors in handling manuscripts submitted for possible publication.<sup>1</sup> There is certainly a paucity of information on the ethical issues that arise between author and editor, but groups such as the Council of Biology Editors have produced important texts on this topic.

Most of the issues that Dewey raises would never have occurred had the journal editor simply followed common courtesy. There is no excuse for holding a manuscript for a year in the review process. If reviewers are too busy to do their job properly (and I recognise their willingness to take on such a thankless task, though it is one that helps the process of science advance) then they should be removed from that task.

Dewey does not mention political issues that arise. I am aware of journals that have held papers under review for almost two years, apparently to prevent publication. I am aware of journals that do not acknowledge receipt of papers submitted to them. I am aware of journals that alter text substantially yet never seek the authors' approval. And I admit to being guilty of one of Dewey's charges: as an editor, I have not shared reviewers' comments with other reviewers, and I have certainly published papers after they have received negative reviews yet may not have explained why to those reviewers who labour so hard on my behalf. I will not do so again.

Ultimately, if a journal editor is to be a gatekeeper of scientific knowledge, procedures must be in place to assure both readers and authors that their work is to be taken seriously. Editors, like scientists, are human and do err. The spirit of fairness, however, mandates that we should treat all papers equally and with candour.

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EDITOR.—Michael E Dewey raises several important issues in his review of problems encountered by authors when dealing with journals.<sup>1</sup> Many of us have had similar experiences. Most of his examples relate to inefficiency or lack of feedback rather than abuse of power (except, perhaps, the issue of the editor as author). To his list we would add that

authors should have the right of reply when a journal has published correspondence critical of their publication.

Authors can also encounter some more serious difficulties. Several years ago we wrote a paper in which we detailed a serious case of abuse of editorial power. A brief outline of the events is that the editor of a major medical journal (a) republished a previously published paper solely in order to attack it in an editorial; (b) did this without the authors' permission, while stating the opposite; (c) initially refused to allow the original authors the right to reply in his editorial criticism; (d) published a further editorial attack when (a year later) he published an edited version of the authors' response; (e) refused to publish any other correspondence about the editorial attacks; and (f) gave another editor a dishonest account of events to dissuade him from publishing our account of the affair. We had full documentation to support these charges. We submitted our paper (or a shortened version) to six journals, including three directly or indirectly concerned in the particular incident, but were unable to get it published. Indeed, one journal never replied.

Though there may be several good reasons why our paper was not accepted (one being that the editor in question was no longer alive), the fact is that there is no outlet for complaints against editorial abuse of power. Editors rightly feel strongly about scientific fraud.<sup>2</sup> The International Committee of Medical Journal Editors should consider the sorts of issue discussed by Dewey and how a mechanism might be set up to allow authors' grievances to be aired.

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1 Dewey ME. Authors have rights too. *BMJ* 1993;306:318-20. (30 January.)

2 Lock S, Wells F, eds. *Fraud and misconduct in medical research.* London: BMJ, 1993.

EDITOR.—I agree with Michael E Dewey that journals should respect authors' rights. A case report on magnetic resonance imaging of the brain of a patient with Munchausen's syndrome<sup>2</sup> has led to speculation that the syndrome may be a "pure organic disorder."<sup>3</sup> Some years ago Lezak and I wrote an article on brain dysfunction in patients with Munchausen's syndrome. We accumulated 25 neuropsychological assessments and estimated that about one third were characterised by serious brain dysfunction. The paper described five cases, in one of which computed tomographic findings were abnormal.

Although well acquainted with rejection notices, we were unprepared for the criticisms of this paper. Seven editors rejected it despite several reviewers indicating that it was well written. Eventually it was accepted by a somewhat obscure journal.<sup>4</sup>

In first submissions we included the neuropsychological data. One reviewer questioned whether the examinations were properly interpreted, and another did not like one test we used. No one, however, sought neuropsychological consultation or reviewed Lezak's book describing our methods.<sup>5</sup> Our next drafts eliminated the test data and focused on the conclusions. Reviewers said that the paper lacked data. Another insinuated that no one had ever seen that many patients with Munchausen's syndrome, let alone tested them.

One reviewer suggested that the patients had fooled us. In fact, all were eager to prove that they were neuropsychologically intact. Most performed in the high average to superior range on measures of verbal learning but had severe deficits in tasks

associated with the non-dominant hemisphere. Like Fenelon *et al* we were uncertain about the aetiology and timing of the damage.<sup>2</sup> Nonetheless, whatever behavioural sequelae existed had been subtly woven into the personality of the patient.

One reviewer told us that case reports prove nothing. Do some screening anyway.

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1 Dewey ME. Authors have rights too. *BMJ* 1993;306:318-20. (30 January.)

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## Liver failure induced by paracetamol

EDITOR.—John Spooner calls on experience when he states that "people bent on suicide who are denied one method will choose an alternative."<sup>1</sup> Though this may apply to certain people, research findings indicate that suicide is at least partly a function of the availability of a lethal method of suicide. A real reduction can be achieved by restricting the availability of such methods.

Coal gas poisoning was a common method of successful suicide until the carbon monoxide content of domestic gas was reduced. Although the number of suicides by other methods rose, this was not sufficient to compensate for the fall in deaths due to coal gas poisoning—indeed, a reduction in suicide of over 30% was observed.<sup>2</sup> Studies on the effect of gun control in the United States have shown that states with stricter laws have lower suicide rates than states where a higher proportion of people own guns.<sup>3</sup>

Paracetamol, although not a common cause of death by suicide, is used increasingly for deliberate self poisoning. A 12 year study of adolescents showed that self poisoning with paracetamol increased from 23.4% of overdoses to 48.3%.<sup>4</sup> The contribution to completed suicides is likely to rise. Serious consideration needs to be given to increasing the safety of paracetamol. Education regarding the potential dangerousness of the drug in overdose may prevent accidental deaths, but it is not clear that this alone will prevent death among those who impulsively overdose with this drug.

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1 Spooner J. Liver failure induced by paracetamol. *BMJ* 1993;306:457-8. (13 February.)

2 Krietman N. The coal gas story. *British Journal of Preventive and Social Medicine* 1976;30:86-93.

3 Lester D, Murrell ME. The influence of gun control laws on suicidal behaviour. *Am J Psychiatry* 1986;137:121-2.

4 Hawton K, Fagg J. Deliberate self poisoning and self injury in adolescents. A study of characteristics and trends in Oxford, 1976-89. *Br J Psychiatry* 1992;161:816-23.

EDITOR.—John Spooner of the Paracetamol Information Centre accuses Gary P Bray of causing confusion in relation to suicide by ingestion of paracetamol.<sup>1,2</sup> Spooner ignores clinical experience by dismissing all such deaths as being deaths of "people bent on suicide." Many who deliberately ingest excessive amounts of paracetamol are unaware of its lethality in overdose, and their behaviour is interpreted as a cry for help. It is not possible to determine the number of such people