

Man-Son-Hing and Wells found a positive result for the drug in all of the six perfectly designed clinical trials that they analysed in their meta-analysis.² I wonder what grounds the authors have for maintaining that "controversy surrounds its efficacy."

The second message is that 53% of the patients in the practices investigated were also taking drugs "known to be associated with cramps" (nifedipine, cimetidine, salbutamol, terbutaline, and diuretics in general) and that the dose of these should be modified or the drug stopped. Cramps are an uncommon side effect of all of these drugs except salbutamol (when taken orally) and diuretics, and when they occur they are not solely nocturnal. It is certainly good practice to try to modify the dose of diuretic when cramps occur, though, interestingly, in one of the less than perfect trials (by Kaji *et al*) cited by Man-Son-Hing and Wells, when quinine was given to patients receiving haemodialysis it proved particularly effective and trouble free. The other drugs quoted are usually given for good indications, and to suggest that they are responsible for the cramps in a considerable proportion of the 53% of patients is guesswork.

The third message, and the most extraordinary, is that quinine is expensive and usually prescribed in practices where the general practitioners are "high cost, high volume" prescribers. There can be several reasons why some practices fit this description. For instance, they may have a high proportion of very young and very old patients; it is elderly patients who most often need quinine. The basic cost of a 300 mg quinine sulphate tablet is about 4p, so four weeks' supply at the usual dose of one tablet at bedtime costs £1.12. Few patients tortured by night cramps would grudge the NHS spending this sum.

Finally, the risk of ill effects from a nightly dose of 300 mg is extremely small. In the serious cases of toxicity described by Bateman and Dyson (cited by the authors) the patients had taken amounts measured in grams, not milligrams, and never less than six times the dose prescribed.³

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Specialist breast and ovarian cancer clinics should be staffed by oncologist nurses

EDITOR,—Harry Campbell and colleagues set out the need for specialist NHS clinics to provide advice to the many women who fear that they are at high risk of breast and ovarian cancer.¹ I agree that such a need exists, but I disagree with the authors' suggested staffing model. Campbell and colleagues suggest that predominantly genetic training is required, whereas I believe that such clinics are best staffed by oncologist nurses with special experience of breast cancer who have been given additional training in genetics. There would, of course, be close links with research centres aiming to clarify the role and take up of genetic testing.

I have found that most women at increased risk of breast cancer are more interested in potential protective options and effective monitoring than in ascertaining their precise degree of risk. A variety of protective options are currently under trial,

including premature termination of ovarian activity, prophylactic mastectomy, tamoxifen treatment, and vitamin K analogue treatment.² Until national selection of the most appropriate treatment is agreed, women at high risk of breast cancer need specialist clinics where they can be given balanced information about the advantages and disadvantages of each type of intervention. Each woman must then make a fully informed decision³ and will be emotionally supported in whichever option she chooses.

Specialist breast cancer clinics of this type may or may not come under the control of each hospital's breast screening organisation, but they will be set up only if women's self help organisations press for their provision. This was the driving force when national screening for breast cancer was set up.

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The 13 steps to community care

EDITOR,—Social services departments and community projects have erected bureaucratic procedures that impede the process of discharging mentally ill people from hospital. For example, in one district the following steps must be fulfilled (this process is typical of the problem throughout London).

- (1) Refer patient for community living assessment (4 pages).
- (2) Allocate worker to complete community living assessment.
- (3) Complete community living assessment form (50 pages).
- (4) Prepare summary and statement of need (3 pages).
- (5) Pass statement of need to community living action group for approval. It may be challenged at this point, and if it is rejected it will need to be rewritten and presented again.
- (6) Identify appropriate accommodation. If there is no vacancy the client may be placed on the waiting list and the process arrested.
- (7) Complete application form (10 pages) and, once medical and social work reports are available, submit them to residential project.
- (8) Succeed at one or more selection interviews at the prospective home. If the interview fails, the process must start again at step 6.
- (9) If patient is accepted, refer to community living action group to agree funding. Placement may be rejected on grounds of cost.
- (10) Complete finance forms, care plan forms, and public service agreements (totalling some 30 pages).
- (11) Make arrangements for moving in (including referrals to community nurse and general practitioner, arrangements for benefits and other personal finances, bus pass, etc).
- (12) Trial period of three months.
- (13) Find social services care manager for case.

This exercise entails over 100 pages of forms and reports and, if there are no mishaps (there always are), takes three months. If no appropriate home can be identified the procedure is of indefinite duration. This protracted process has the effect of delaying moves, thereby causing patients to "silt up" in admission wards. This in turn leads to difficulties in admitting acutely ill patients to wards and to overoccupancy¹ as well as stoking the

burgeoning industry in extracontractual referrals at growing cost to the health service.

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BMA should look at inequalities in the NHS

EDITOR,—The BMA's board of science and education argues that inequalities in the health status of the British people persist and regards this as an indictment on a health care system created to provide equal and free access to health care for all, irrespective of income.^{1,2} The board suggests that the recent reforms of the NHS, rather than improving the situation, may have been detrimental to the principle of equity. It calls for the government to reduce inequalities by taking action in areas related to income, housing, education, taxation policy, behavioural factors (for example, smoking), psychosocial factors, genetic issues and issues of early life, ethnic minorities, geographical location, leisure activities, and transport. The responsibility for inequity is placed firmly on the government and the patient. Only one sentence in the board's report relates to the process of medical care, acknowledging its importance in reducing variations in morbidity but cautioning readers that it cannot account for the substantial variations in mortality that exist.

Is it reasonable for the medical profession and others who work in the NHS simply to look elsewhere for the contributory causes of inequality? Should not a concern for inequality start with an examination of how the NHS and its doctors differentiate between rich and poor people? The BMA seems reluctant to discuss the fact that those who pay for health care can expect:

- speedier access to an outpatient consultation
- the outpatient consultation to occur in hospitable surroundings, with more time being given to them by the consultant
- a greater likelihood of surgical intervention (for example, although only 11% of the population is insured, over 30% of hip replacement operations are paid for privately³)
- a shorter wait before being operated on
- the operation to be performed by the consultant.

The BMA has recently expressed concern over the establishment of a private primary health care service, saying, "It would worry us if any private company were to pick off patients on the basis of ability to pay."⁴ Is there not some hypocrisy in this attitude when the medical profession remains willing to treat an increasing number of private patients not because of their clinical need but because of their ability to pay?

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- 4 Laurance J. BUPA to offer home visits from GPs for busy patients. *Times* 1995 Oct 16:9.