Infectivity of pneumonic plague

EDITOR,—Peter Cowling and Peter Moss support the view that pneumonic plague is highly infectious.[1] It is certainly lethal unless treated vigorously at an early stage by antibiotics. This, however, does not prove that it is highly infectious as, say, measles or influenza is. Of the patients in an overcrowded ward during a large outbreak of plague in Kenya in the 1940s, only one certainly and one probably acquired the disease in the ward. The certain case was in a paralysed patient occupying the bed next to a patient who died expectorating *Yersinia pestis*. Most of the patients dying of plague whose lungs were affected were in the last stages of bubonic plague, but the diffuse pneumonia in the lungs of others indicated true pneumonic plague—that is, plague acquired by inhalation of the bacillus.

An outbreak of pneumonic plague also occurred in Tanzania in 1972; the disease was brought into a village by a hunter, who presumably carried fleas or flea faeces from an infected wild rodent. A sharp outbreak ensued, which was confined to adjacent huts or intermingling relatives. Before the diagnosis was made a medical attendant in a local mission hospital died of pneumonic plague acquired from a patient. Once the diagnosis was made no further fatalities occurred in hospitals, the nurses and medical attendants being protected by a sulphonamide or streptomycin. Only one other fatal case occurred in the village after the whole population was given a prophylactic sulphonamide. The diagnosis was later confirmed by serological testing in a specialist laboratory. I was present throughout both of these outbreaks.

The notorious epidemic in China at the beginning of the 20th century took place under intensely cold conditions, when the subjects slept huddled together in small circular huts. Close proximity to the sufferer seems to be necessary for transmission of the disease. The differing death rates from bubonic plague before the introduction of sulphonamides or antibiotics indicated that the virulence of *Y pestis* varied, and possibly the degree of its infectivity also varies.

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1 Cowling P, Moss P. Infectivity of pneumonic plague. *BMJ* 1994;309:1369. (19 November.)

Certifying incapacity for work

EDITOR,—The item in Medicopolitical Digest concerning proposed changes to the certification of medical incapacity for work may mislead doctors about the changes that have been proposed for the introduction of incapacity benefit next April.[1] Ministers announced last year that, as part of the changes, the role of general practitioners as gatekeepers to long term incapacity benefits would be greatly reduced. Entitlement to incapacity benefit after the first six months of incapacity will be determined by the application of a new "all work" test. Once this test has been applied general practitioners will no longer need to issue medical statements to certify continuing incapacity for work. At no time have we proposed asking general practitioners for an opinion on eligibility to incapacity benefit. Furthermore, from next April the law would not allow it.

Most spells of absence due to sickness are for shorter periods and involve a claim for statutory sick pay administered by the patient's employer. General practitioners currently issue Med 3 certificates for this purpose, and there are no plans to change this arrangement. Nor are there any plans to change the current arrangement for self certification during the first seven days of incapacity.

It is of paramount concern that patients who are incapacitated for work are supported in their claim to state benefits with appropriate clinical information about their condition. The patients' own doctor is the person best placed to supply such clinical detail, and we have not sought to alter this.

We have proposed a new medical statement for use in incapacity benefit, which, for the first time, will allow general practitioners to provide a certificate to their patients for social security purposes only. Provision of this statement, which will be within general practitioners' current terms of service, also gives doctors the opportunity to include a full diagnosis of the condition(s) causing incapacity for work. As a result we expect a substantial reduction in the number of occasions when the Benefits Agency medical services request a factual report (RM2) from the patient's doctor. We have also proposed replacing the standard RM2 forms so that doctors give a more focused and relevant report on the patient. Far from increasing general practitioners' workload, these proposals are aimed at substantially reducing long term certification work and the number of medical reports that general practitioners are obliged to complete.

In developing our procedures we have taken careful note of all the concerns expressed by the profession and the representative bodies. General practitioners we have spoken to have welcomed these proposals and are happy to support their patients by supplying appropriate medical information. We have liaised closely with the BMA over these proposals, and I am disappointed at the stance taken recently by the General Medical Services Committee.

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1 Beecham L. GPs will not police social security system. *BMJ* 1994;309:1163. (29 October.)

Determining the number of psychiatric beds needed

EDITOR,—We support Graham Thornicroft and Geraldine Strathdee's view that it is not possible to debate the issue of how many psychiatric beds are needed without placing the emphasis firmly on the whole mental health system.[1] But the notion that pressure on inpatient beds could be eased by more efficient management by "senior clinical gatekeepers" is too simplistic. The suggestion that the crisis in acute inpatient services would end if only clinicians managed their services properly is being repeated so often that it is beginning to be believed. As with all such statements, there is some truth in it, but it does little for the morale of an already demoralised service and provides the Department of Health with another stick with which to beat clinicians rather than encouraging the department to confront the real issue of resources.

The purchase of acute admission beds within the private sector has increased considerably to compensate for their lack in the NHS, and this has become a regular feature of many acute units in London. This change in provision is aligned in our service to a decrease in the overall number of admissions from 1459 in 1992-3 to 953 in 1993-4 with a pronounced increase in the average length of stay (mean 21·4 days in January 1994 and 31·5 days in September 1994). The percentage of detained patients has also increased considerably, from 40% (589/1459) to 58% (553/953). These changes have occurred despite no absolute reduction in beds occurring and alongside the development of our increasingly effective community mental health service.

The length of stay increased most after the introduction of the care programme approach and the first phase of the supervision register. When used properly the care programme approach slows throughput, and there is no doubt that community teams and consultant psychiatrists are now far less willing to take risks concerning discharge; previously, taking such a risk was the only means by which a bed could be freed for a potentially more disturbed patient. Mental health teams managing their own beds from admission to discharge is an exciting model being implemented in some services, including our own, and should lend a coherence to patients' care, but whether this model will result in a reduction in the number of beds required has yet to be proved.

The need for safe standards in community services has been recognised. We would point out, however, that while minimum safe staffing levels operate for inpatient units, these units are increasingly experienced by patients and staff as threatening and at times dangerous environments.

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1 Thornicroft G, Strathdee G. How many psychiatric beds? *BMJ* 1994;309:970-1. (15 October.)

Ethics of rationing health care services

EDITOR,—Unlike Raanon Gillon,[1] I find myself agreeing with the King's Fund when it advocates the formation of a Oregon-like commission modelled on the Nuffield Council of Bioethics to start the process of rationing of specific services.[2]

Gillon doubts whether it is morally safe to use, as he sees it, "populist solutions in distributive justice such as have occurred in Oregon . . . and technical and simplistic economic solutions such as the system of costed quality adjusted life years (QALYs)."[1] Instead he favours seeking ways of "muddling through elegantly" as advocated by Hunter in *Rationing Dilemmas in Health Care*.[3] Gillon is offended by moral choices being converted into apparently scientific numerical methods and formulas.

His criticism seems to centre on the notion that every case must be considered on its merits. By focusing on the admittedly pseudoscientific formulations used (Alan Maynard described the ranking process used in Oregon as nothing more than a crude guesstimate),[2] he fails to address the underlying issue of whether it is morally right in principle to decide on what a person is entitled to expect from the health service and what that person should not expect from the health service. Surely one person's elegant muddling is the same as another's irrational decisiveness. How are we to tell the difference?

In a just health system a patient should be able to expect equality of access to health care which is free at the point of service,[4] in the way which was originally intended 46 years ago. To my mind, this is not to be achieved by elegant muddling. Elegant muddling implies an unwillingness to face up to hard choices.

Gillon quotes Calabresi and Bobbitt, who suggest that health professionals are like jugglers trying to keep too many balls in the air[5]; like the juggler we must do our best to improve our juggling skills to keep more balls in the air for more of the time and to avoid letting any ball stay on the ground for too long.