Letters

Consultants' new contract

Surely shome mishakhe?

Error— I think that there must be a mistake and I have downloaded the wrong contract from the BMA's website.1 The one I downloaded offers a 4% pay rise in return for a 16% increase in my clinical workload. Further pay rises are at the whim of my managers, to be paid five years in arrears provided that I meet conditions over which I have no control or work unpaid overtime.

The contract I downloaded is a licence to enable my managers to order me in for routine surgery and clinics on weekday evenings, Saturdays, and Sundays, for no extra pay, while paying me £1 an hour to be on-call at other times. Could someone please send me the other contract that Peter Hawker and the BMA are hailing as a resounding victory for my colleagues and me? While I vote no to what is clearly a different contract.

William Westlake consultant ophthalmologist Truro TR1 3 LX willandsam@willandsam.fsnet.co.uk


So called victory in private practice obscures real contractual problems

Error—Reports on the proposed consultant contract have focused too heavily on the concessions obtained over private practice and the headline figure of a 20% pay rise.2

The pitfalls of the contract far outweigh this victory.

Firstly, few doctors will immediately, or in the near future, get a 20% rise in pay. Essentially we are being promised a 20% rise staged over 20 years, or 1%/year. For many this rise will be offset in part by loss of domiciliary fees, category 2 work, and the loss of intensity payments. My own pay rise will be 2.5%—hardly a princely sum given I work full time for the NHS.

Secondly, the new contract seeks to make evening working up to 10 pm and weekend morning work an acceptable part of the working week, remunerable at standard rate. I find this appalling. Junior doctors have spent years fighting to be remunerated at above the standard rate for working unsociable hours. Should it be any different for consultants? And if the aim is to keep people in hospital medicine why pursue such family unfriendly initiatives?

Thirdly, too much control is being handed to managers—both in terms of when work is done and when salary increments are paid. The new salary introduces two forms of performance related pay: the revamped merit award scheme and the basic pay spine. Didn’t the BMA fight a long campaign against performance related pay a few years ago? What happened?

The contract does not fulfil any of its core objectives. I now feel undervalued by my employer and my trade union. I want to retire even earlier. I think a no vote can be taken as read.

Simon Smith consultant psychiatrist South Shropshire Community Mental Health Trust, Ludlow, Shropshire SY8 1DA si.smith@freeuk.com

1 Hargreaves S. Government makes U turn on private practice ban. BMJ 2002;324:1473. (22 June.)


Advice to authors

We prefer to receive all responses electronically, sent directly to our website. Processing your letter will be delayed unless it arrives in an electronic form.

We are now posting all direct submissions to our website within 24 hours of receipt and our intention is to post all other electronic submissions there as well. All responses will be eligible for publication in the paper journal.

Responses should be under 400 words and relate to articles published in the preceding month. They should include ≤5 references, in the Vancouver style, including one to the BMJ article to which they relate. We welcome illustrations. Please supply each author’s current appointment and full address, and a phone or fax number or email address for the corresponding author. We ask authors to declare any competing interest. Please send a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

bmj.com

letters@bmj.com

Private practice is unlikely to be main cause of long waiting lists

Error—The new consultant contract introduces job plans for hospital consultants1 Full time consultants are to have a working week made up of 10 “programmed activities” of “typically four hours each,” seven of which will be “devoted to direct clinical care.” The contract also states that “NHS consultants’ commitment to the NHS must take priority over any work undertaken for other organisations.” The clear implication is that consultants, because of their perceived focus on earning private income, are at least one of the causes of inefficiency and long waiting times, particularly for elective surgery.

In November and December 1997 we carried out a prospective audit of all elective general, vascular, urological and breast procedures in patients scheduled for preoperative assessment or admission to Southamption University hospitals to establish the proportion of operations cancelled and for what reasons. There were no red alerts during this time.

Of the 851 patients identified, 847 (99.5%) had data available. Of these, 106 (12.5%) had urgent planned admissions, the remainder being asked to attend a preoperative assessment clinic. Of these, 61 (82.3%) did not attend. Of those who did attend, 30 (4%) had their procedures postponed or abandoned, 22 because of medical problems and eight because of social problems or patient preference.

Altogether, 769 patients were scheduled for admission, including those receiving urgent planned admission. Of these, 123 (16.3%) had their operations cancelled before admission, and three failed to attend hospital on the due date. Eighty five operations were cancelled because of lack of a bed, nine because of lack of theatre time, and six for medical reasons; 13 admissions were cancelled by patients, and in only 10 was the reason for cancellation not recorded. Of the 630 patients admitted, a further nine had their operation cancelled, five for medical reasons, three because of lack of theatre time, and one because the patient refused to give consent. No cases on which data were available were cancelled because of the lack of availability of a surgeon to conduct the operation.

Although this study was carried out in 1997, there has been no marked change in the service provision in most NHS hospitals since. Anecdotally, Southampton University Hospitals NHS Trust is typical of most large teaching hospitals. Lack of beds and theatre time constitute by far the largest reasons for cancellation of planned surgical admission. Increasing the available time of surgeons will accomplish little without a corresponding increase in the number of available bed days and theatre hours. The NHS infrastructure needs urgent attention, not consultant contracts. Whatever the attitude to the desir-
Weak negotiators strike again

EDITOR— I left the NHS two years ago when the morale of consultants was, I thought, at an all time low. We had been rendered essentially powerless by hospital managers, who paid a low salary for our expertise and clinical commitment, and were the victims of continual government spin depicting us as lazy, uncaring, unsafe Bentley-driving moneygrabbers with huge private practices. I was particularly frustrated that our representatives, the BMA, repeatedly failed to assert our real position and always seemed to climb down when challenged by negative spin. I can see now that nothing has changed.¹

This new contract is an appalling deal, and I am astounded that the BMA negotiators consider it a victory. If you offered the equivalent deal to any other professionals, such as barristers or dentists, they would laugh at you. Hospital porters would not accept the extension of the normal working day as proposed in the contract. Some consultants in the middle bracket will actually take a pay cut. The only significant pay rise is the £10 000 for newly appointed consultants, who, in reality, will no longer be able to do any significant private practice as the extra eight hours’ commitment to the NHS will prevent it. The £10 000, in fact, is not a pay rise because any consultant doing eight hours a week in the private sector would make far more than £10 000 a year.

The BMA negotiators think that the government has climbed down on the seven year rule for newly appointed consultants when, in reality, consultants’ private practice has been restricted for life. Any consultant wishing to pursue private practice will have less time to do so under the new contract. He or she will almost certainly not get the £5000 pay rise every five years that is given at the discretion of hospital managers (who now, more than ever, are the powerbrokers).

In the Republic of Ireland, consultants are represented by a very strong organisation fronted by people who are not medically qualified. They are hard negotiators who are not dependent on merit awards or potential inclusion in the Queen’s honours list. Thus they act exclusively on behalf of consultants. If consultants accept this deal, it is only a matter of time before they will be clocking in and out with the cleaning and catering staff. The new contract is an insult to highly skilled dedicated professionals who have made significant personal sacrifices to be where they are today.

Aidan P Gleeson consultant in accident and emergency medicine Beaumont Hospital, Dublin, Republic of Ireland apgleeson@uacx

New contract means cut in pay for part time consultants

EDITOR— I have been a consultant for 14 years. I work part time, seven sessions, and participate in a 1 in 4 on-call rota. If I transfer to the proposed new contract I will take an immediate cut in pay of £1000. I will not regain my current salary level until 2006, and it will be 2008 before I recoup my lost earnings. My so-called pay rise will begin in 2008-9, an average of 2% per year over the following five years (subject to managerial approval and assuming that there are sufficient funds to afford it). This is the reality of the proposed new contract for me. It seems a long way from the headlines of 22 June.¹

My vote will be a clear no to the negotiating team’s proposals. The proposed move to a 40 hour week significantly disadvantages all consultants who work on a less than full time basis. It would seem the negotiating team either forgot we exist or believe we are a low priority group compared with others.

I recommend all consultants who work part time, particularly those who have been in post around four or five years, or more, get out their calculators. You may well find that your negotiators have negotiated a pay cut for you.

Diana C Webster consultant NHG Grampian, Summerfield House, Aberdeen AB15 2RE diana.webster@ghgrampian.scot.nhs.uk

The negotiating committee should come up with a new agreement

EDITOR— The framework agreement has removed our ability to work in a professional manner and organise activity for the benefit of our patients.¹ The idea of the rigid session during which attendance in the hospital is mandatory means that no activity will be started in future if it might over-run the end of a session. In addition, there will be no stimulus to be efficient and get more done as an early end to the session is now not rewarded. Although this flexibility is abused by a small minority of doctors, the vast majority use it to organise work as efficiently as possible.

Am I to be paid for my meal breaks? If not, I will have to take them as a matter of right as I would be a complete fool if I worked over a lunchtime without being paid. The new contract rewards the clock watcher and treats the doctor who stays until the job is done as an idiot. The only staff left on a professional contract will be managers, and I am afraid I simply do not trust statements such as “we would never interpret the contract in that way.” If it is written down, it can be enforced.

I do not understand why, as a consultant of some 14 years, I will take me 23 years from appointment to reach the salary maximum, whereas a newly appointed consultant would take 19. I wrote to Douglas Bilton, acting secretary of the Central Consultants and Specialists Committee on this matter and was told that this was the best that could be done to bring the deal in under the financial limits imposed. I have no problem with new consultants being awarded a decent salary, but I object strongly to my colleagues and me being discriminated against. We are the group who did a large number of appalling rotas and did not get the salary or time off given to current trainees. Why should we be penalised again? If the contract needs to be phased in, then an equitable scheme for all should be sought.

Although the idea of payment for emergency work and so on out of hours is laudable, sessions to cover such work commitments have always been negotiable locally. All that has happened so far is that this principle is to be formalised nationally, but with the loss of recognition of the nature of unsocial hours.

We can do much better, and for the good of the service we certainly ought to. The negotiating committee should take this framework back.

Crispin Best consultant paediatric anaesthetist Royal Hospital for Sick Children, Glasgow G3 8SJ crispin@compuserve.com

Summary of responses

EDITOR— By 3 July 22 respondents had sent us 23 responses to the two news items on the consultants’ new contract.¹ Sixteen respondents were scattered throughout England, from Truro to Newcastle; three wrote from Scotland, and one each from Belfast, Dublin, and Jersey. Four were consultants in various subspecialties of anaesthesia or psychiatry, two were consultant physicians, and two were consultants in accident and emergency medicine. The 10 other respondents were from a wide range of disciplines, including academia, radiology, endocrinology, and clinical neurophysiology.

Condemnation of the contract was unanimous.

Graeme Weiner, a consultant otoaryngologist in Exeter, rushed to read the latest on the contract in the BMJ of 22 June but was incredulous to find there was none. He suggests the journal commission an article “by a couple of employment law specialists (and perhaps a human rights lawyer) so that we may see how truly awful the proposed framework is.”

Others criticised the use of spin in reporting the new contract. Lesley Wilson, consultant old age psychiatrist from Jersey, said that the BMJ’s headline was unfortunate and “will tend to support the widely held...
Gold for the NHS

No natural limitation exists on demand for services free at point of supply

Editor—By far the most encouraging sentence in Robinson's editorial is the last: "There is a strong case for arguing that UK healthcare policy should be driven by the supply side rather than the demand side reform." Yet there is not a word of this from the chancellor or the secretary of state or in the report by Wanless, whose terms of reference guaranteed his conclusions. Even working within those limitations Wanless managed to generate some gratifying drive, saying that the cost of health care is likely to fall as we take greater measures to improve our health.

There may have been some excuse for Aneurin Bevan's assessment of budgetary realities, but surely 54 years' unvarying experience has been enough to convince us of the truth of another health secretary's assessment (Enoch Powell's): there is no natural limitation on the demand for any good or service free at the point of its supply. Until that is grasped and fully understood, those working in the NHS will continue to be the poorly paid providers of inferior care to an ungrateful public.

Brian Campbell
consultant physician
Acute Medicine, Western General Hospital, Edinburgh EH4 2XU
Kelly.Black@lht.scot.nhs.uk

1 Robinson R. Gold for the NHS. BMJ 2002;324:987-8. (27 April)

What exactly is being bought with this gold?

Editor—Two concerns came to me when I read Robinson's editorial about the plans for unprecedented rates of growth in NHS spending.1

The first is, what exactly is the government buying with the extra billions it is spending on the NHS? Is it hoping to buy more medical treatment on behalf of the public? Is it hoping to make the population healthier by so doing?2 If it is the first of these then the government has some hope of achieving its aims, although where the extra staff are going to be brought from is not clear. If the government is hoping to make a difference to the overall health of the public by spending through the NHS system it is mistaken. Any treatment system such as the NHS can only deal with the casualties of life, not with how to live healthily in the first place.

This brings me to my second concern: that simply concentrating on supply side measures will pander to medical vanity (treatment as all important) and move thinking away from looking at how and why demand for medical services arises in the first place.

Unless we as individuals and as a society are able to encompass the full picture of health, including its environmental factors, its social relationships, and its political and moral dynamics, we will continue to find health puzzling and frustrating. We must start to examine the sources of demand for health care and learn to modify them early. This will require courageous medicine and courageous politics.

Peter Davies
general practitioner
Misenden Stomes Surgery, Halifax HN2 8RQ
rippdavies@doctors.net.uk

1 Robinson R. Gold for the NHS. BMJ 2002;324:987-8. (27 April)
2 Moore W. NHS to receive an extra £4bn over next five years. BMJ 2002;324:955. (27 April)

Postcode prescribing is alive and well in Scotland

Editor—We had understood that one of the intentions of the National Institute for Clinical Excellence (NICE) was to rationalise the introduction of new drugs and technologies across the United Kingdom so that NHS patients would have equitable access. This has plainly not happened. We illustrate the problem with three recently licensed drugs, imatinib, trastuzumab, and irinotecan.

Imatinib has yet to be appraised by the National Institute for Clinical Excellence, but our local haematologists completed the paperwork for approval by Lothian Health Board's drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.

Irinotecan was approved by the National Institute for Clinical Excellence and the Health Technology Board for Scotland. However, the drug evaluation panel for Lothian has rejected it—despite knowing the decisions of the institute and the board—on the grounds that the improved survival does not justify the cost. If the patients live in the west of Scotland, however, they can receive it. In Aberdeen doctors are allowed to prescribe it but without any additional funding, so that expenditure on irinotecan competes with that on other drugs.

Trastuzumab was approved by the institute after a year's deliberation, and then by the Health Technology Board for Scotland. It is already available in the west of Scotland; but recognising that the real decision about its availability in the east of Scotland lies with the Lothian Health Board, we have to carry out a detailed assessment of the total cost before applying to the drug evaluation panel. The only reason we have any optimism about its decision is that some funding may already have been identified.

The current system seems no more equitable than previously; extra layers of central committees exist, and drug availability continues to depend on local health board decisions. We would advocate a streamlined approach, with centralised decision making bodies such as NICE and the Scottish Medicines Consortium. Any deci-

Sharon Davies
letters editor, BMJ

1 Electronic responses. Government makes U turn on private practice ban. bmj.com 2002. (bmj.com/cgi/content/full/324/7352/1475/a#responses; accessed 3 July 2002.)
2 Electronic responses. Juniors call on consultants to reject new contract. bmj.com 2002. (bmj.com/cgi/content/full/324/7352/1478/a#responses; accessed 3 July 2002.)
In 1979-96 Wales have not identified any missed cases from that experienced in the United Kingdom, despite significant potential improvements in case identification, but all of their decisions. The alternative is a return to the old system of postcode prescribing. This, however, would require politicians to acknowledge that local health boards have the right to set different priorities and are prepared to take the clinical consequences of their decisions. 

New variant Creutzfeldt-Jakob disease: the critique that never was

Editor—Venter’s article on new variant Creutzfeldt-Jakob disease (vCJD) is intended to stimulate debate, which we hope will be better informed than the article itself.

Is variant Creutzfeldt-Jakob disease a new disease? Venter places great emphasis on Creutzfeldt’s case, but this patient did not have Creutzfeldt-Jakob disease. The illness was characterised by gait disturbance, a relapsing and remitting course, nystagmus, and status epilepticus. These are not the clinical features of variant Creutzfeldt-Jakob disease and, crucially, the neuropathological appearances were “not characteristic of Creutzfeldt-Jakob disease.”

In 1996 confidence in the novelty of variant Creutzfeldt-Jakob disease was based largely on the identification of a neuro-pathological phenotype that was distinct from that experienced in the United Kingdom from 1970. Since then archival issues have been reviewed in many countries and no past cases with a similar neuropathology have been found. Retrospective epidemiological surveys in England and Wales have not identified any missed cases of variant Creutzfeldt-Jakob disease from 1979-96. Current evidence strongly supports the hypothesis that variant Creutzfeldt-Jakob disease is indeed a new disease.

Was variant Creutzfeldt-Jakob disease identified solely because of improved surveillance? There was a doubling in the apparent death rates for sporadic Creutzfeldt-Jakob disease in the United Kingdom between the 1980s and the 1990s, but similar increases in the apparent death rates for sporadic Creutzfeldt-Jakob disease had occurred in other European countries. These countries have been subject to similar potential improvements in case identification, but variant Creutzfeldt-Jakob disease remains a disease occurring predominantly in the United Kingdom, despite significant numbers of young suspect cases being investigated in each country (figure).

Venter argues correctly that the curve for the epidemic of variant Creutzfeldt-Jakob disease does not parallel the number of cattle with bovine spongiform encephalopathy (BSE) between 1983 and 1988. However, human exposure to the BSE agent almost certainly extended to 1996 and depended on a range of variables not addressed by his model. These include the species barrier between cattle and humans, the numbers of cattle in the final year of the incubation period, the load of bovine central nervous tissue entering the human food chain, the efficiency of legislative measures, and temporal changes in food production. Extrapolation from conventional foodborne epidemics to epidemics of variant Creutzfeldt-Jakob disease and BSE is clearly too simplistic.

A wealth of laboratory evidence supports the hypothesis that the BSE agent is the cause of variant Creutzfeldt-Jakob disease. Venter states correctly that there is no direct evidence that the BSE prion is infectious to humans, but obtaining such evidence would be difficult to justify ethically and as this would involve inoculating humans with the agent. A judgment on the link between BSE and variant Creutzfeldt-Jakob disease inevitably depends on an assessment of a range of clinical, pathological, epidemiological and laboratory based evidence. There is now overwhelming evidence that BSE is the cause of variant Creutzfeldt-Jakob disease, although there remain uncertainties about the future number of cases and the mechanism of transmission of BSE to humans.

R G Will consultant neurologist
R S G Knight consultant neurologist
H J T Ward consultant epidemiologist
J W Ironside director
National Creutzfeldt-Jakob Disease Surveillance Unit, Western General Hospital, Edinburgh EH4 2XU

1 Venters GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:856-61.

The technique of Jakob’s two patients was reviewed by the neuropathologist C L Masters in 1982, who found that these hallmarks of Jakob’s did not have any evidence of a spongiform encephalopathy. Only his later patients had changes typical of Creutzfeldt-Jakob disease. The first two

vCJD: the epidemic that never was

New variant Creutzfeldt-Jakob disease: the critique that never was

Editor—Venter uses Creutzfeldt’s original case report of 1921 as an argument against the existence of a “new” variant of Creutzfeldt-Jakob disease (CJD). Creutzfeldt described a patient who presented to his department aged 23.

She was the youngest of five children, two of whom had mental retardation. The patient’s parents were both dead, the cause of death of the father’s death was not known, the mother had died of a “non-neurological” disease when the patient was 1.4. In her late adolescence, the patient was thought to be odd, as she continued to play with dolls and exhibit other childlike behaviour. Aged 21, she refused to eat, claiming that she wanted to lose weight. At the same time, her gait was noted to be “heavy.” Aged 22 she developed a symmetrical rash affecting her face, later also both hands, her groin, and both feet. She was found to have spastic legs and tremor in all limbs. While on a dermatology ward she had a “hysterical seizure” with arc de cercle. It is not clear how she was treated, but all of her symptoms, including the gait disorder, improved.

One year later the gait deteriorated again. At the same time the patient refused to eat or wash, complained about chest pains, and exhibited agitated and paranoid behaviour or inappropriate laughter. On admission to the neurology department she was pyrexia at 38.9°C, incoherent and not oriented in time or space. Her speech had a staccato quality. She had myoclonic limb jerks, intention tremor, myoclonus, limb tone, brisk tendon jerks, hyperaesthesia, and hyperalgesia. She gradually deteriorated over three months and died in status epilepticus characterised by tonic seizures, seizures with Jacksonian march, and clonic jerks.

From a clinical point of view, family history, relapsing course, and skin rash would argue against a diagnosis of “variant” or sporadic Creutzfeldt-Jakob disease. More importantly perhaps, Creutzfeldt’s meticulous histopathological report does not mention spongiform change (conspicuous in almost all known cases of Creutzfeldt-Jakob disease) or florid plaques (one of the hallmarks of variant Creutzfeldt-Jakob disease). Creutzfeldt’s original pathology slides were reviewed by Jakob who thought the changes were identical to those seen in two of his own patients.

The tissue of Jakob’s two patients was reviewed by the neuropathologist C L Masters in 1982, who found that these hallmarks of Jakob’s did not have any evidence of a spongiform encephalopathy. Only his later patients had changes typical of Creutzfeldt-Jakob disease.
patients certainly did not have new variant Creutzfeldt-Jakob disease. Perhaps we should drop the “C” from Creutzfeldt-Jakob disease.

Markus Reuber, specialist registrar
Department of Neurology, Leeds Teaching Hospital NHS Trust, Leeds LS9 7TF
mreuber@doctors.org.uk

1 Venetis GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.
4 Richardson EE, Masters CL. The neurology of Creutzfeldt-Jakob Disease and conditions related to the accumulation of PrPsc in the nervous system. Brain Pathol 1995;5:53-41.

Possibility of BSE being cause of variant CJD is indeed biologically plausible

Editor—Venters argues against bovine spongiform encephalopathy (BSE) causing variant Creutzfeldt-Jakob disease. In fact, the biological plausibility of this being the cause, the strength of the epidemiological association, and the experiments indicating that the same prion is involved are all good.

Incubation periods for BSE are proportional to the life expectancy of the animal affected. The disease's incubation period is 18% of a cow's life expectancy and would be proportional to the life expectancy of the animal that the same prion is involved are all good. This is exceptional evidence that the same prion is the cause.1 PrPsc associated with BSE will alter human normal prion protein to the abnormal form in vitro, but it is not surprising that transgenic mice expressing human prion protein did not become infected easily with BSE.

Steve Deailer, consultant in medical microbiology
Burndley General Hospital, Burnley BB10 2PQ
deailer@airtime.co.uk

1 Venetis GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.
2 Deailer SF. Should young UK cattle be considered free of BSE or is it endemic? Br Vet J 2001;157:264-90.

Author has overlooked several findings that support his argument

Ennorn—Venters's reappraisal of variant Creutzfeldt-Jakob disease (vCJD) is important1 because, even if new cases of the disease continue to be reported sporadically or in an occasional cluster, there is no evidence of an epidemic anywhere.2 But in dismissing the misfolded prion glycoprotein that “causes” bovine spongiform encephalopathy (BSE) as the cause of variant Creutzfeldt-Jakob disease,3 Venters overlooks other findings that support his argument.1

Firstly, BSE began in dairy herds in 1986, almost immediately after the Ministry of Agriculture, Fisheries and Food removed controls on foodstuffs for cattle and mandated supplementary feeding with proteinaceous offal, often containing scrapie material, to increase milk production.

Secondly, suckler-fed, grass-fed pedigree herds were virtually unaffected unless they were in contact with dairy cattle.

Thirdly, BSE, subsidised when supplementary feeding with proteinaceous offal was banned.

Fourthly, ascertainment of unpreceded intensity has shown an excess of five forms of Creutzfeldt-Jakob disease in the United Kingdom since 1989 but no excess of variant Creutzfeldt-Jakob disease in those at high, continuous, and percutaneous risk of occupational exposure to actual BSE—namely, veterinarians, and people working on farms and in cattle markets, abattoirs, butchers' shops, and abattoirs.

Fifthly, the same ascertainment has identified variant Creutzfeldt-Jakob disease in younger people with questionable levels of presumed exposure from ingestion of cooked beef or beef products possibly containing BSE. An increase in incidence, from 0.8 confirmed cases per million in 1995 to 1.2 in 2000, is continuing, along with an overall increase in total (including iatrogenic) referrals but a decrease in all other forms of Creutzfeldt-Jakob disease. Surveillance of relevant neurological disease in children in the United Kingdom since 1997 has yielded only three cases, although suspect prion is present in tonsils.

Prusiner and his team give reasons for regarding scrapie as the common cause of BSE.4 But there are genetic and other reasons, as above, for questioning the hypothesis that BSE is directly transmissible to humans. Although published as a witness statement in the BSE enquiry,5 these reasons were not discussed in the ensuing (Phillips) report, which preferred to conclude that BSE originated as a mutant of scrapie in the 1970s.6 It was contended to accept common causation on the basis of endpoint similarities in neuropathological features of variant Creutzfeldt-Jakob disease and BSE, as observed in cattle and in transgenic mice bred with the gene for BSE prion and then inoculated intracerebrally with brain material from cattle with BSE.

Factual evidence about the revolution in animal feeding and the nil incidence of variant Creutzfeldt-Jakob disease in close human contacts at highest risk is giving way to artefactual experimental results in mice supporting a hypothesis that BSE prion can cross a further species barrier to cause variant Creutzfeldt-Jakob disease in humans.7 8 9 10 This is the scientific hypothesis now used to maintain speculation that anyone who eats British beef or beef products has a lifetime risk—perhaps present, 1.2-1.5 per million persons per annum—of developing variant Creutzfeldt-Jakob disease and starting an epidemic.

Gordon T Stewart, emeritus professor of public health, University of Glasgow 29/8 Inverleith Place, Edinburgh EH3 5QD g.stewart@gifford.co.uk

1 Venetis GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.

Has medicalisation of childbirth gone too far?

Regional analgesia in labour permits childbirth without fear

Ennorn—Several points in Johanson et al’s review on the medicalisation of childbirth deserve comment. Firstly, maternal mor-
timality related to anaesthesia has declined dramatically over the past few decades. Recent surveys from both the United Kingdom and the United States find that the few fatal complications of anaesthesia in obstetrics are usually related to complications of general anaesthesia—for example, loss of airway or hypoxia.1 2

The decline in the use of general anaesthesia for caesarean delivery must partly be attributed to the rise in use of regional analgesia during labour.3 In fact, the American College of Obstetricians and Gynecologists has issued a statement saying: “Failed intubation and pulmonary aspiration of gastric contents continue to be leading causes of maternal morbidity and mortality from anaesthesia. The risk of these complications can be reduced by careful antepartum assessment to identify patients at risk, greater use of regional anaesthesia when possible, and appropriate selection and preparation of patients who require general anaesthesia for delivery.”4

Johanson et al’s paper states that women are “encouraged” to receive epidural analgesia in labour. This paternalistic attitude ignores the fact that most women in labour choose epidural analgesia of their own volition, without influence. I believe firmly that the choice for women to elect to undergo natural childbirth should always be available (within the limits of safety with regard to certain high risk conditions), just as some of us choose to climb mountains or run marathons. This should also be accompanied by the attitude among all obstetric and anaesthetic care providers that there is nothing “wrong” with women who choose natural childbirth.

But most people do not run marathons or climb mountains. And most women do not want to have pain during childbirth. The widespread use of regional analgesia in labour should be celebrated as one of the blessings of having a baby in this millennium. Pain free childbirth has become as much a part of modern culture as the mobile phone or the microwave oven.

Johanson et al state that “Childbirth without fear should become a reality for women, midwives, and obstetricians.” As one of the cardinal fears of labour is pain, the widespread availability and use of regional analgesia should go a long way towards reducing this fear.

William Camann director of obstetric anesthesia Brigham and Women’s Hospital, Harvard Medical School, Boston, MA 02115, USA wecamann@partners.org


Timely intervention is the key

Evolving general practice consultation in Britain

Pregnant women at term with rupture of membranes before labour are subjected to routine induction of labour. Again, the paternalistic approach offers no choice. Expectant management for even the next 12-24 hours is perceived as too risky an alternative. Even pregnant women at 36 weeks’ gestation are subjected to the same routine protocol.

All women in labour undergo routine midline episiotomy. Every woman is subjected to this regardless of gestation (term or preterm). The episiotomy rate approaches 100%.

The above practices are so entrenched that any change of practice would meet much resistance. Increasing medicalisation has led not only to diminishing but to increasing numbers of medicolegal cases. A vicious cycle ensues. Obstetricians now act and intervene even more for fear of litigation.

Government health statistics show that the number of registered midwives declined in the past decade, from 1801 in 1990 to a mere 508 in 2000. During the same period the number of registered doctors rose from 19921 in 1990 to 29585 in 2000. This is for a population of 20 million in 1990 and 22 million in 2000.1

As Taiwan now seeks observer status in the World Health Organization, professional bodies and governments in Taiwan should promote obstetric practice as contained in the WHO report Care in Normal Birth: A Practical Guide, which aims at improving obstetric practice in normal childbirth.2

Peter S Yeh senior resident in obstetrics and gynaecology Taipei Adventist Hospital, Taipei 105, Taiwan yehpeter@hotmail.com

completed the general health questionnaire-12; doctors estimated psychological distress using a six point scale and recorded important outcomes of the consultations. Consultations were timed by a research assistant.

Data were collected from 781 consultations. When booking interval was increased by 50% consultation length increased by 12% from 8.7 to 9.7 minutes. Longer booking intervals significantly increased the number of consultations in which the doctor arranged investigations (19.4% vs 27.9%; P = 0.0069) and follow up appointments (43.8% vs 53.7%; P = 0.0072). There was no significant effect on the proportion of consultations in which prescriptions were issued (51.0% vs 54.7%; P = 0.34), physical examination carried out (66.8% vs 66.8%; P = 0.96), or referral made (14.0% vs 10.7%; P = 0.20).

There were no significant differences in identification of psychological distress between long or normal booking intervals (odds ratio 1.00 (95% confidence interval 0.85 to 1.00)).

Although booking interval increased by 50%, consultation length increased by only 12%. This raises the question of what the doctors did with the extra time. It has been argued that increasing the length of consultations will save time and resources. Our results suggest that the opposite is true: doctors ask more patients to make follow up appointments after longer consultations and perform more investigations. Perhaps doctors give more time with patients simply uncover more problems. The lack of impact of an increased booking interval on the recognition of psychological distress in patients suggests that structural constraints are insufficent to explain low rates of recognition of distress by general practitioners.

Our results must be interpreted with caution. A more sustained intervention might have led to more major changes in consulting behaviour. Our data suggest, however, that longer consultation intervals may cost more than remuneration for extra general practitioners' time.

Phil Wilson
general practitioner
paulson@climned.gla.ac.uk

Alex McConnachie
statistician
Department of General Practice, University of Glasgow, Glasgow G12 0RR

Mark Stirling
general practitioner
Ferguson Medical Practice, Brodhead Health Centre, Brodhead EH52 1JZ

Longer consultations might necessitate redeployment of pharmacists

Editor—Freeman et al open an overdue debate about the length of consultation times. They address the question of why consultation times should be longer but do not consider how this might be achieved.

The workload in primary care is increasing faster than the workforce is. This is fuelled partly by demography, partly by increased health expectations, and partly by developments in treatment. The unremitting commercial gameplaying of the pharmaceutical industry, highlighted in an article in the same issue of the BMJ as Freeman et al's article, adds another turn to this screw.

General practitioners are fully occupied. There is no prospect of a huge increase in the general practitioner workforce in the next decade. The only way for doctors to have more time is therefore for them to stop doing things.

There are a few activities that general practitioners might simply stop doing. Some may need legislative change, such as a move from repeat prescribing to repeat dispensing. This would probably save the average general practitioner about an hour a day. Other changes might need us to question some of our routine behaviours perpetuated by the convoluted fee structure of general medical services. Why do we need to see patients taking contraceptives twice a year? Why do we still dabble in antenatal care when midwives do it so much better? What is a “full postnatal examination” for?

The most effective way of freeing up time is to delegate. Get someone else to do it—preferably someone who is better at it than you are. The extended roles of practice nurses and nurse practitioners are a move in this direction, but there are so many calls on nurses that we are probably close to the limit of available staff. The largest untapped source of underused skill, however, is community pharmacists: the fact that so many are trapped behind their counters selling baby food and offering cold remedies of questionable efficacy is a waste of their clinical skills.

The future of the traditional high street pharmacy is threatened by the pincer movement of industrialised warehouse dispensing and the supermarket pharmacy. At present supermarket pharmacies are contributing to a manpower shortage, but warehouse dispensing could reverse this trend. The potential exists to redeploy pharmacists into general practices to review patients and supervise drugs, making best use of their knowledge and developing skills.1, 3 This would free up general practitioners and enable them to extend consultations and improve the depth and breadth of care.

Arnold G Zernamsky
general practitioner
A.G.Zernamsky@leeds.ac.uk

David K Raynor
lead, Pharmacy Practice and Medicines Management Group
Duncan Petty research pharmacist
School of Healthcare Studies, University of Leeds, Leeds LS2 9LT

Nick Freeman
professor of clinical epidemiology and biostatistics
Department of Primary Care and General Practice, University of Birmingham, Birmingham B15 2TN

The lot of airline pilots and consultants is not so different

Editor—“A day in the life of a hospital consultant: is it so different from that of an airline pilot?” Awake from a restless night. Study the latest directive from the flying越来越少.

Finish off writing lecture notes on emergency landing procedures. Set off to airport via a charity coffee morning to receive cheque to buy a new pilot seat.

Arrive Stansted. Pilots’ car park full of ground crews’ cars, so have to park some way away and walk to check-in.

Take morning flight to Paris. Mid-channel find out that there is only one trained air steward in the cabin and the rest are steward assistants; go back to help. Standing room only because of 30 overbookings.

Land; sprint across tarmac and take 9 am flight to Copenhagen. During flight do two appraisals of navigators, answer 10 written complaints about cuisine, and lecture flight staff about latest safety procedures.

Land at Copenhagen. Race across tarmac and take 11 15 am flight to Brussels. Land 1 pm on two sets of wheels as one set now 15 years old (application to lottery fund for new set failed). Receive round of applause for good landing and a visit from a passenger whose duty free goods fell on his head.

Take flight to Athens. Co-pilot is new style trainer with 10 minutes’ flying experience. During flight talk down two other landings because staff are inexperienced.

Arrive Athens 3 pm. Immediate turnaround. Flight back to London Stansted 7 pm. Find car wheel clamped. No problem as blew went off and I had to take emergency cargo flight to Glasgow. Big bonus: I was able to wave goodnight to the children as I flew over the house. Arrive Glasgow in the early hours of the morning; canteen shut so grab stale sandwich from vending machine and try to grab an hour’s sleep in airport terminal chair.

Still, it was better than yesterday.

Colin Trask
consultant in radiology and oncology
Southend Hospital, Southend SS0 0RY
colin.trask@southend.nhs.uk

1. McDonald E. One pilot son, one medical son. BMJ 2002;324:4105. (4 May)
