

the needs of other deserving practices are still not being met.

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Improving London's health service

Now comes the hard part

After a century's diagnosis of the ills of London's health service many in Britain will welcome almost any prescription that stops 15% of the population consuming 20% of NHS resources. But for those living and working in London the decisions made last week by the government (see p 537)¹ have to face a harder test. Will they improve or worsen the standard of care given to Londoners—and to a wider group of patients who use London's specialist services and benefit from its research and teaching?

Many people have been disappointed that last week's decisions were not more precise—defining, for example, exactly what should happen to St Bartholomew's or Charing Cross Hospital. But London's pattern of hospitals is such a historical muddle that no one can wave a wand and transform everything overnight. Restructuring will inevitably entail compromises, and it is important that those who have to make the compromises work should be involved in fashioning them. In general Mrs Bottomley has set clear boundaries and timetables for the decisions and told the relevant authorities to work out their own salvation within them. In return she should ensure that her mechanisms for protecting research and education are robust enough to enable London's hospitals to operate fairly within the internal market.

The boundaries make sense, but there is an air of indecent haste about the timetables. Even though many of Sir Bernard Tomlinson's recommendations, now endorsed by the government, worked with the grain of changes already occurring,² some of the timetables are short. The specialty reviews, for example, have to assess current and projected needs, define criteria for tertiary services, and advise on the most cost effective and clinically effective locations—all by the end of May. This work will not be done in a vacuum,^{3,5} but for a problem that has existed for at least a lifetime a few more months of thought might lead to better outcomes, and ones that will be more readily accepted.

Likewise, the agent of change might have been better devised to give more confidence in the outcome. At present the London Implementation Group smells too much of hole in the corner deals: the working part of the group consists only of two named people, one of them a former Thames regional chairman, and the ordinary members of the specialty review committees (see p 589) and of the all important Primary Health Care Forum had not yet been announced as we went to press. The group might knock heads together but it doesn't seem designed to do the equally important job of explaining what is happening to staff and patients. And Londoners need explanations and reassurance. Over the past few months they have been told that their primary and community health care

is awful; now the government tells them that accident and emergency departments will shut, along with 2000-odd hospital beds, when their immediate evidence is that it is hard to get into hospital. Likewise, the implementation group's human resources subgroup sounds too low key to convince staff that the NHS will tackle the problems of maintaining morale and preserving skills while changes go on.⁶

Part of the problem for Londoners is that the notion of transformed primary and community care, breaking down the boundaries between hospital and community, is still unclear. The government has accepted Tomlinson's recommendation for investment in premises and has set up an initiative zone to encourage new ideas. There are plenty of good ideas around,⁷⁻¹⁰ but the worry is that the sheer difficulty of practising in inner cities will overwhelm even the most enthusiastic practitioners and managers¹⁰ and that they will "settle for more of the same . . . but out of better buildings."¹¹ Much will depend on the leadership and vision of the Primary Health Care Forum.

Perhaps the biggest gap in both the Tomlinson report and *Making London Better* concerns research and postgraduate teaching. The government has already decided to bring special health authorities into the internal market. It also wants a market in research, and it promises a mechanism for funding the excess costs of academic teaching and clinical research. But there is little inkling of how the mechanism will work, and we have to wait until December for the management executive and the Department of Education to come up with ideas. They are badly needed: as Green has said, "It would be easy for clinical research to become the first and indeed the greatest casualty of reductions in size in London."¹¹ This is particularly true since London has a pressing need for a shift in acute beds towards those serving elderly Londoners with multiple diseases and away from younger patients with interesting single diseases (J James, MSD Foundation symposium, 1992).¹² London may just be carrying too big a burden of research and teaching for its population—but the means by which research and education get redistributed, rather than simply shut, remain unclear.

It is easy to criticise the government's decisions: after a century of inertia, making changes in London was always going to be difficult, and Mrs Bottomley deserves credit for getting the process started. But she needs to remember that deciding strategies is easy; implementing them is hard. She has given a lot of commitment to the strategy; she now needs to give as much to the process of change and to ensuring that the public understands it.

Londoners have for long been perversely proud of a health

service that does not serve them well. They now have a chance of a better one—but they need to be able to recognise that.

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Treating bed wetting

Bladder exercises, star charts, enuresis alarms, and now ERIC

Bed wetting is not the most glamorous of paediatric problems; treating it, however, can be highly rewarding because treatment is so often successful. There are an estimated 500 000 sufferers aged between 6 and 16 in Britain. From reports of management within enuresis clinics¹ it is reasonable to predict that 400 000 might be curable.

Nocturnal enuresis alone, particularly if primary, is both a disorder of maturation and a genetic trait. Compared with controls, patients are three to four times more likely to have a parent who had been enuretic.² They are also more likely to have excessive diffuse slow background activity on electroencephalography³ and are significantly shorter than controls.⁴ Minor neurological dysfunction is common, including mild hypotonia, problems with coordination or fine manipulation, and mild dyskinesia.⁵

Many such "clumsy children" have learning problems, emotional difficulties, and problems with relationships. These may be provoked by the lowered self esteem that many suffer as a result of teasing and criticism by peers, parents, and teachers. Within this group the wetters do even worse. Add to these handicaps serious life changes or stress, such as parental separation,⁶ and the setting is complete for the misery, embarrassment, and shame of bed wetting.

Daytime and mixed day and night wetters have certain aetiological differences from night wetters, although there is much overlap: they are more likely to have had an adverse perinatal history, their bladder capacity tends to be smaller, and they are more likely to suffer urinary tract infection. It has been suggested that their urological dysfunction may be a marker of perinatal neurological damage, but in a study of 191 wetters those with dyssynergic bladders and increased residual urine were also those with the most severe behavioural problems.⁷

The most effective treatment is dry bed training^{8,9} and an enuresis alarm. Devlin and O'Cathain found that of 122 children consecutively referred, 22 became dry after a structured interview (with the child alone as well as with a parent), advice on personal hygiene and cleanliness training, daily bladder exercises, and provision of a "star chart."¹⁰ These authors supplied a further 96 children with an enuresis alarm; 81 achieved initial success (42 consecutive dry nights) at a mean of 7.3 weeks (range 1-26 weeks). Eleven required a second try, of whom nine achieved dryness.

Success is more likely when the problem is maturational and less likely when there is psychiatric disorder of the child, severe family stress, absence of concern by child and parents, urological dysfunction, and developmental delay.¹ Other poor prognostic signs may be coexisting day wetting¹⁰ and maternal intolerance of the enuretic child.¹¹

Drugs have a minor role: tricyclic antidepressants have little effect and are not suitable to be kept in households where there is a combination of young children and stress. Oxybutynin is unhelpful¹² except, perhaps, in children whose enuresis is part of a syndrome including frequency, urgency, dysuria, and covert bacteriuria.

Desmopressin, 20-40 µg nightly intranasally is effective during treatment in 12% to 70% of cases; only up to 31% remain dry after the course of treatment. There is no long term advantage of three months' over one month's treatment.¹³ It may be of most value for occasional use, in known responders, to save embarrassment when sleeping away from home. It must not be prescribed without a careful history; if the child's real problem is not enuresis but psychogenic polydipsia, desmopressin may provoke water intoxication and hyponatraemic fits (RAF Bell *et al*, personal communication).

Patient and parent support groups are often valuable in paediatric practice. The Enuresis Resource and Information Centre (ERIC) is a registered charity providing advice and information to children, parents, and professionals. It runs a confidential telephone counselling service and publishes material for teenagers, parents, and others. Taking a leaf from the book of other lobby groups, it is in the process of publishing guidelines on minimum standards of clinical practice and offering a consultative service to purchasers on their implementation.

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