Wielding the propaganda weapon

SIR,—Scrutator is concerned with examples of disinformation, and one of the subjects he considers is the hours of work of junior doctors.[1] He may be spreading disinformation himself.

He quotes, with seeming approval, from a letter written by a junior doctor who suggests a way ". . . to force hospitals to cut overtime. . . ." The implication is that junior doctors (and senior doctors) are lined up outside managers' doors with schemes designed to cut hours but managers will refuse to consider them until punitive overtime rates are introduced. I do not believe this is the case.

Any scheme to reduce hours must include no more than the present number of juniors (at the insistence of the profession), must be acceptable to seniors and juniors in terms of patient care, and must be approved by colleges and faculties as suitable for training. There is little scope for an immediate reduction of hours of work without the appointment of more staff. The only grade at which this can be done is that of consultant. Is the profession prepared to identify work for consultant posts that is very different from the traditional model? The difficulties of having two types of consultant in the same service as set out in *Achieving a Balance*[2] have not yet been faced or have been faced and rejected.

Scrutator ends his column by quoting, again with some approval, a junior doctor whose answer to the unacceptable state of affairs is that ". . . doctors must work a shift system like everybody else." It is not clear how this will solve the problem, unless it is believed that juniors are not fully employed during their standard working week. Patient care has to be delivered, and any change in the timing of that delivery would have major repercussions on other staff groups. There is evidence that a change to shift working would require a major increase in numbers.[3]

There is no single answer to the problem. Perhaps there is no answer at all. I am sure that no manager will turn away plans from groups of doctors who have proposals that apply locally. The solutions lie just as much with the profession as with managers. But what have district working parties been doing for the past three years?

D H VAUGHAN

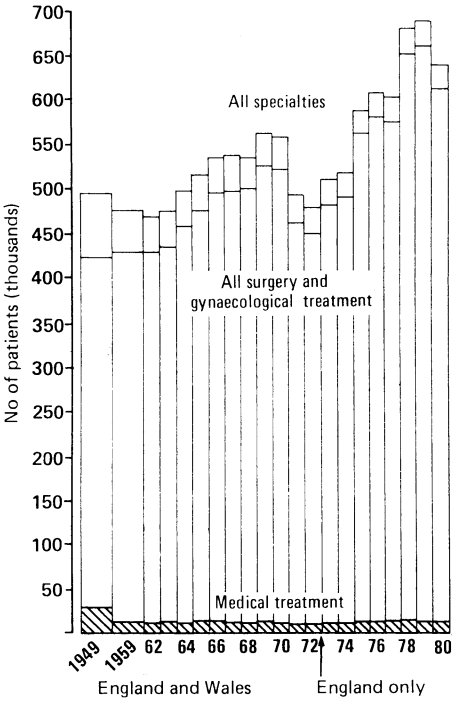
North Western Regional Health Authority,
Manchester M60 7LP

1 Anonymous. Wielding the propaganda weapon. *Br Med J* 1990;**300**:422. (17 February.)
2 United Kingdom Health Departments, Joint Consultants Committee, Chairmen of Regional Health Authorities. *Hospital medical staffing—achieving a balance—a plan for action.* London: HMSO, 1987.
3 Wilson AM, Weston G. Application of airline pilots' hours to junior doctors. *Br Med J* 1989;**299**:779-81. (23 September.)

Increasing hospital waiting lists

SIR,—I would like to present a graph from a report I submitted to the Royal College of Surgeons in 1984 that is relevant to the one on hospital waiting lists published in the news section.[1] It confirms the steady increase in the size of the waiting lists, not only from 1979 but also from 1949. My report confirms, also, that two thirds of the waiting lists belong to general surgery; traumatic and orthopaedic surgery; ear, nose, and throat surgery; and gynaecology. To this it is pertinent to add that cardiothoracic surgery accounts for less than 1%. In the west midlands there were only 547 patients who were waiting for admission for cardiothoracic surgery out of a total waiting list of 58 813. Moreover, the number of patients waiting for a medical admission was well under 5% of the total.

The graph shows that in 1949 the NHS inherited a ready made waiting list for surgery and gynaecological treatment of 498 000; that is over half the size of the current waiting list. This inherited burden has always been ignored.



Size of hospital waiting lists from 1949 to 1980

By using the Californian relative value weighting system to link the length of an operation to the number of 3·5 hour sessions required it was calculated that it would take 20 years to get rid of the existing waiting list, with the proviso that 17 extra theatres (if they could be staffed) in each of the 14 English regions would be needed. Obviously the NHS in 1948-9 was set an impossible task.

F S A DORAN

Herefordshire HR8 1DH

1 Delamothe T. Hospital waiting lists to increase. *Br Med J* 1990;**300**:350. (10 February.)

Sectioning of patients with visual difficulties

SIR,—We recently had occasion to detain a 70 year old patient with a toxic confusional state under section 5(2) of the Mental Health Act. The patient had congenital optic nerve atrophy and was unable to read leaflet 3, section 5(2) entitled "Your rights under the Mental Health Act 1983," which health authority managers are required to give all patients who are being detained under the act. Our patient demanded a copy of this leaflet in Braille. Fortunately we were able to cater for the special needs in this case through the kind offices of the Royal National Institute for the Blind. Inevitably, however, there were delays in organising matters to meet this request that extended well beyond the 72 hours of the original section.

Had our patient not been able to read Braille we would not have been able to offer an alternative. Although the headings of official leaflets that explain the rights of those being sectioned under the Mental Health Act are in bold print, the detailed practical information is in fine, small, closely spaced print. From studies that have looked into the ability of elderly patients to read the print on drug labels[1] there is reason to believe that many would have similar problems with the Mental Health Act leaflets. Leaflets have recently been produced in Welsh, and we understand that versions in other languages are soon to follow. It would perhaps be helpful if the visual needs of elderly patients could also be considered in the setting out of such documents.

RUTH SEYMOUR

Department of Geriatric Medicine,
Cardiff Royal Infirmary,
Cardiff CF2 1SZ

DAVID MILLAR-JONES

Llandough Hospital,
South Glamorgan CF6 1XX

1 Zuccollo G, Liddell H. The elderly and the medication label: doing it better. *Age Ageing* 1985;**14**:371-6.

New arrangements for registrar appointments

SIR,—We are now approaching our first registrar appointment under the new arrangements, which entails setting up a committee, at regional rather than district level, consisting of a minimum of five people. As expected, there have been delays in sorting this out. This will necessitate in the first case having to employ a locum for about six weeks.

The interview also requires the presence of four consultants from our hospital at a regional meeting for a whole afternoon—that is, four consultants' afternoons wasted. Previously this interview would have been at district level and taken place at lunchtime with virtually no loss of working time.

Obviously this will be the harbinger of many future registrar appointments, particularly those that crop up unexpectedly—that is, with a month's notice. The whole system is time consuming and wasteful and has been thought out by an administration that has little concept of the practical problems of working in a busy general hospital.

G J ARCHER

Stepping Hill Hospital,
Stockport SK2 7JE

Performance indicators

SIR,—Our community health council believes that most people would prefer early outpatient consultation even though this will cause a longer "waiting time" before surgery—waiting time being defined by the Department of Health as the time from being entered on the waiting list by the consultant to being admitted to hospital. But as waiting time is a performance indicator the administrators seem loath to take action.

Are there other instances of performance indicators—as defined by the department—encouraging worse performance—as judged by patients?

M K WILLIAMS

Surrey KT1 2BT

Correction

Why are the Japanese living longer?

Two editorial errors occurred in this letter by Dr Geoffrey P Walsh (17 February, p 465). The reference in the second sentence should have referred to the proceedings of the American Oil Chemists' Society's conference and not those of the American College of Osteopathic Surgeons as published. The third sentence should have read: "This may be more provocative of cerebral haemorrhage in Westerners with previously healthy vessels than in those with previously unhealthy atheromatous ones and, added to Japan's salt based hypertension problem, may account for its high incidence of haemorrhagic stroke."