The new single organising principle?
Ham and colleagues are partly right that there is no inherent contradiction between pursuing competition and integration simultaneously.¹

The difficulty with the current debate is that we are stuck in the paradigm of commissioning/competition/choice, and we are trying to find reasons and workarounds to justify this. We keep pursuing the panacea of purchasing and markets, which has failed since its introduction by the Thatcher government. I do not see how the much needed integrated model exemplified by Torbay and the Veterans Health Administration can be built on the general practice commissioning platform.

Yes, commissioning may make some difference in a small part of the comprehensive healthcare needed by the population, and it might work in some geographical areas, but will it work for all services and in all places? I doubt it, so any small gains from commissioning have to give way to the bigger needs of integration. It is time to stop justifying commissioning and time to adopt integration as the new single organising principle for the NHS.

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Horses for courses
Brimblecombe justifies her suggestion that the NHS reforms are already working by claiming that “quality generalism is where the future lies.”² But is that where she would place the care of her own family, instead of in the hands of “academics and specialists.”³

As one of those specialists, I spend increasing amounts of time correcting the results of—for example, inadequate minor surgery carried out in the community, including incomplete excision of skin cancers. With respect, just as family doctors are experts at dealing expeditiously with family problems, I am expert at dealing with surgery after years of training. Yet to Brimblecombe, it seems quality can be cheap.

She claims cost savings, but Salisbury and colleagues showed that, as one example, dermatology in the community is twice as expensive, with no quality gain, as it is in hospital.² Curiously, Salisbury’s double blinded evidence has subsequently been suppressed in favour of the mantra that reforms must always be good for patients. There are doubtless other similar, as yet unanalysed, examples of false promise.

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Shared care/blame arrangements
I am surprised that the dermatology team reporting this case, after starting the patient on azathioprine, “asked the GP to check the patient’s full blood count” on a weekly basis for a month (and, presumably, automatically expected this to happen), yet suggest that they had signed up to a shared care arrangement.¹ Every time I receive such a request I politely tell the team in question that until the dosage of the drug in question is stabilised (which can take up to three months), the onus of prescribing and monitoring the drug rests with the secondary care department.

Perhaps if GPs are more careful about prescribing in such dangerous scenarios, we will avoid repeats of this presentation.

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IMPACT OF REDUCED WORKING HOURS
Fundamental purpose of EWTD
Hornitz states that Moonesinghe and colleagues “concluded that these restrictions have had no negative impact on patient care and medical education.”¹ In fact, they concluded that reducing working hours to less than 80 a week has not adversely affected patient outcomes and postgraduate training “in the US” and that the reports on the effects of European legislation
Many residents under-report hours

I do not believe the results of any of the published studies performed in the US after 2003. The recommendations of the Accreditation Council for Graduate Medical Education (ACGME) have put faculty members and trainees in a difficult position. Some specialties are very demanding. ACGME’s recommendation not to let first year residents work more than 16 hours continuously may not be practical—some neurosurgical procedures take more than 24 hours. Many residents therefore under-report their duty hours to their programme directors. They have even created a term “working under the table.” On paper, everything looks all right.

Pilot studies were performed at teaching institutions to see if residents were accurately reporting their work hours. MacGregor and colleagues found that surgical residents did not always record their work hours accurately, that most (52%) under-reported work hours, and many felt that further work hour restriction would be detrimental to their training.7 Carpenter and colleagues concluded that the work hour restrictions have created an ethical dilemma for residents and that many residents (69%) feel compelled to exceed work hour regulations and report those hours falsely.8

In the opening paragraph, Horwitz also says: “one of the fundamental principles behind these reforms was to improve patient safety,” citing a statement from the Accreditation Council for Graduate Medical Education in the US. However, the fundamental purpose of the European Working Time Directive (EWTD) was “to protect the health and safety of workers,” including doctors in the UK, rather than improve patient safety. Similarly, the BMA’s campaign for fewer working hours was largely based on the health and safety of junior doctors. 4 We must not lose sight of the fundamental aim of EWTD when conducting studies to assess its impact. A study that explores whether EWTD has improved the health and safety of doctors rather than looking at its effect on clinical outcomes and quality of training would be useful.

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1 Horwitz LI. Why have working hour restrictions apparently not improved patient safety? BMJ 2011;342:d1200. (22 March.)


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LESSONS FROM FUKUSHIMA

Patients’ psychological distress

The challenge now is to learn as much as possible about the medical effects of radiation. 1 At the time of the earthquake, I was providing antenatal care in Tokyo. Ironically, I was 36 weeks’ pregnant. By 15 March, I was swamped with questions about the continuous effect of low dose radiation on pregnant women—levels in Tokyo were 20 times higher than before (0.8 μSv).2 I wrote many permissions for patients to leave the country by air, but many were unable to travel and felt trapped. I gave the only information I knew: a chest radiograph and 12 hours’ air travel both result in comparatively higher exposure to radiation than remaining in Tokyo, but both are considered relatively safe during pregnancy.

I found a review article on cancer incidence after Chernobyl, which suggested a possible risk of leukaemia but lacked data on other cancers from in utero exposure. 3 A colleague with 50 years’ experience said he had never seen birth defects from the Hiroshima atomic bomb. Later, the Japanese Society of Obstetrics and Gynaecology recommended pregnant and nursing mothers to go as far away as possible from Fukushima and for those exposed to >50 000 μSv to take potassium iodide to prevent thyroid cancer. 4 Many patients seemed dissatisfied with this information. Like me, they wanted to know the effects of long term chronic low dose, rather than acute high dose, radiation exposure. I felt powerless—I had a responsibility to warn patients of the risks but had no clear way to quantify them.

In providing health advice when evidence is limited, doctors must also consider the psychological stress experienced by patients.
POSITIVE BIRTH EXPERIENCE

Midwife led care may not be appropriate or cost effective

The King’s Fund report states that one of the “key underpinning principles” of maternity health policy is that “all women, regardless of risk profile, should be offered the most positive birth experience possible.”

American researchers have recently added to the growing body of evidence that women planning a caesarean birth are more likely to have a positive experience than those planning a vaginal birth, the caesarean group reporting higher satisfaction with planned vaginal and planned caesarean birth. 1

Planners of caesarean birth are more likely to have a positive experience than those planning a caesarean birth, says King’s Fund. 2

The hypothesis that it is the most cost effective approach and the inference that women at low risk can be reliably identified and should all choose a midwife over an obstetrician.

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NEW DRUGS FOR HYPONATRAEMIA

Authors’ reply

Grant suggests that tolvaptan could reduce hospital stay in acute neurosurgical patients, but quotes a study on patients with heart failure. 2 He indicates that one tolvaptan tablet could reduce hospital stay by more than two days. But the study found that daily administration of tolvaptan for 11 days was similar to placebo for 13 days in terms of patient discharge. Thus 11 doses were needed for a two day saving in hospital stay. Most importantly the difference of two days in this study was not significant, and the patients were not neurosurgical ones.

The long term effect of tolvaptan remains unknown, because currently we have only poor quality short term data. Worryingly, sudden death was more common in patients taking 60 mg tolvaptan than in those taking placebo, 3 with the reason being unclear.

The use of tolvaptan in acute neurosurgical patients is especially dangerous. It is difficult to differentiate between the true syndrome of inappropriate antidiuretic hormone hypersecretion and cerebral salt wasting, and the additional diagnosis of inappropriate administration of tolvaptan can muddy the water in these patients. Many patients become hyponatraemic after administration of perioperative fluid, so all we are doing is adding one more factor to confuse the on-call biochemist.

We recommend caution before tolvaptan is used in the acute neurosurgical emergency. Accurate fluid balance is what is needed, and tolvaptan is a dangerous substitute for careful clinical examination.

Competing interests: None declared.

1  Mayor S. More women at low risk of problems should have midwife led care, says King’s Fund. BMJ 2011;342:d1495. (7 March.)
Cite this as: BMJ 2011;342:d2298

CANNABIS USE AND PSYCHOSIS

Are results relevant?

Kuepper and colleagues’ results are based on the Munich version of the composite international diagnostic interview (M-CIDI), which is not a valid diagnostic tool, so any clinical interpretation should be made cautiously. 2 The CIDI itself was devised as an epidemiological tool, and the psychosis component has poor predictive validity when compared with clinical measures, such as hospital registers and clinical judgment. 3

A Finnish population based study found that this instrument would have found “only one third of the subjects with non-affective psychotic disorders or substance-induced psychotic disorder,” and in another study it was found to have a positive predictive value of about 0.2 and specificity of 0.6. 4 Although the authors have tried to improve its validity by using interviewers trained to the level of clinical psychologists, it is unclear how they corrected for these deficiencies within the instrument, and whether this would improve validity (with no use of a gold standard).

Crucially, no mention is made of the number of symptoms expressed using the M-CIDI, or whether those scoring positive were requesting help or receiving psychiatric treatment. In other words, elegant large scale epidemiological studies such as this can clarify and here largely

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The secret of the “team around the child” is the common assessment framework (eCAF) promised (19 January 2011) on the national enabled functionality was much less than a “traditional” multi-user access were hard to come by, and the possibility that this requires a “lead professional to coordinate provision “faster, more coordinated support” for children protection conference. The latest update (22 July 2010). The comparable period of time without mass shootings did not differ between countries in the period 1980-96. In New Zealand, the types of firearms Australia banned are still widely used by citizens for target shooting and hunting. The comparable period of time without mass shootings in both countries, despite their different legislative approaches to ownership of firearms, does not support the view that prohibition of certain types of firearms in Australia is responsible for the absence of mass shootings.

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I wonder whether Mills has tried the online conferencing for child protection that he proposes. Over the past 20 years I have been involved in various synchronous discussions, using technologies ranging from post-it stickies on walls to phones, videolinkage, wikis, and international online debates. A handful of good friends in a videoconference has sometimes agreed a decision. Bringing invisible strangers from diverse professions and services synchronously together online can stimulate the imagination but is not a recipe for agreement on actions.

Initially, ContactPoint was supposed to provide “faster, more coordinated support” for professionals in agencies working with children on some “sensitive” issues, but after hundreds of millions of pounds and many broken spirits it was finally abandoned. Accounts of synchronous multi-user access were hard to come by, and the functionality was much less than a “traditional” child protection conference. The latest update (19 January 2011) on the national enabled common assessment framework (eCAF) promised “secure, fast information sharing,” and for some purposes there may be optimism, but general practitioners must realise that “the CAF process is not a ‘referral’ process but a ‘request for services’ and ‘families do not have to engage.’” In a rapidly evolving, high risk situation, this reduces its value. The secret of the “team around the child” philosophy is its aim to help practitioners come together to decide a course of action. The Children’s Workforce Development Council found that this requires a “lead professional to coordinate the work.” Walker and I described one model of a clinician in a lead professional role for child protection.