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LETTERS

CLINICALLY INTEGRATED CARE

Lessons from Whitby

On the basis of our experience of informal integration between clinicians in primary care, secondary care, and social services in Whitby—a small town in North Yorkshire—I would like to add three points to Ham and colleagues' discussion.[1]

We have had to integrate our expertise because of long term insufficient funding. This lack of funds has generated innovation in order to survive. The recent interest shown by several mental health services from London in our practices reflects their current resource and overhead pressures.

The main objective of integrated care is to set up care pathways for major disease groups, such as cancer and dementia. Integration of whatever type results in pre-ordained pathways, with a variable evidence base, often applied to populations dissimilar to those studied. The rigidity of these pathways makes them difficult to "escape" from—for patients and clinicians. The alternative approach would be through patient held budgets (involving a health and social care charge card), where care pathways are organically forged by frequent use. This process permits escape when changes of diagnosis and client characteristics necessitate this.

In Whitby we have used informal integration for patients, carers, and professionals to learn from each other; a "learning network."[2] Working together and subsequently reflecting on real life episodes of care have increased our collective competency and promoted smarter ways of intervention (often earlier than conventionally stipulated).

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Competing interests: None declared. This letter reflects the author's personal opinion only.

1 Ham C, Dixon J, Chantler C. Clinically integrated systems: the future of NHS reform in England? *BMJ* 2011;342:d905. (28 March.)
2 De Silva PN. New ways of working with primary care: proactive CMHT or polyclinic? *Progr Neurol Psychiatry* 2009;13:6-11.

Cite this as: *BMJ* 2011;342:d2406

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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1 Ham C, Dixon J, Chantler C. Clinically integrated systems: the future of NHS reform in England? *BMJ* 2011;342:d905. (28 March.)

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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."[1] But is that where she would place the care of her own family, instead of in the hands of "academics and specialists."

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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Competing interests: None declared.

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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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1 Wee JS, Marinaki A, Smith CH. Life threatening myelotoxicity secondary to azathioprine in a patient with atopic eczema and normal thiopurine methyltransferase activity. *BMJ* 2011;342:d1417. (25 March.)

Cite this as: *BMJ* 2011;342:d2412

IMPACT OF REDUCED WORKING HOURS

Fundamental purpose of EWTD

Horwitz states that Moonesinghe and colleagues "concluded that these restrictions have had no negative impact on patient care and medical education."[1 2] 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

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are of "poor quality and have conflicting results, meaning that firm conclusions cannot be made." With specific reference to the UK, they add that the impact of reduced working hours has "not yet been sufficiently evaluated in high quality studies."

In the opening paragraph, Horwitz also says: "one of the fundamental principles behind these reforms was to improve patient safety,"[1] 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,"[3] 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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Competing interests: None declared.

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Many residents under-report hours

I do not believe the results of any of the published studies performed in the US after 2003.[1] 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.[2] Carpenter and colleagues concluded that the work hour restrictions have created an ethical dilemma for residents and that many residents (49%) feel compelled to exceed work hour regulations and report those hours falsely.[3]

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1 Moonesinghe SR, Lowery J, Shahi N, Millen A, Beard JD. Impact of reduction in working hours for doctors in training on postgraduate medical education and patients' outcomes: systematic review. *BMJ* 2011;342:d1580. (22 March.)
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INDIAN GENERIC DRUG PRODUCTION

EU-India free trade agreement

Love repeats many myths surrounding the free trade agreement (FTA) and ignores the benefits to India from balanced provisions for intellectual property.[1] He says that negotiations are being conducted "in secrecy," but then criticises their alleged content. He offers hyperbole and straw men: "The EU has asked India to sacrifice access to life saving drugs for market access in other areas of the economy," "Trade officials in Europe want India to implement a similar regimen" to the European one, or the EU wants to "remove India as a legal market for early production of generic drugs."

He does not know this is true, and the reference fails to support his assertions. No other FTA has adopted a European-type regime. Negotiations have always centred on creating intellectual property provisions that match the country's developmental stage.

Love also ignores the positions of the European Commission and the research based drug industry. Both say that the FTA should not undermine access to drugs in developing countries; industry already works with Indian generic manufacturers to ensure the production volumes required. Presumably these facts do not fit the narrative, so were ignored.

He argues that the FTA would affect the developing world because few developing countries have a large enough domestic market to attract entry by suppliers of generic drugs. But the growth of the Indian generic sector has been built on its exports, not its domestic market, and has been particularly strong since the 2005 Indian Patent Act, which was also predicted to cause the demise of generic manufacturers.

A well constructed, balanced EU-India FTA will benefit both parties and all sectors. To suggest otherwise would deny India's strong science base access to the tools and security it needs to create its own research based industry.

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Competing interests: None declared.

1 Love J. The production of generic drugs in India. *BMJ* 2011;342:d1694. (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.

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Competing interests: None declared.

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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."[1]

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 ratings, higher scores for fulfilment, lower scores for distress, and lower scores for difficulty.[2 3] The King's Fund report, however, does not recognise that for low risk women who plan a prophylactic caesarean birth (the informed decision to deliver at 39 or more weeks' gestation to avoid the unpredictable infant and maternal risks associated with a trial of labour), midwife led care is not appropriate: obstetrician led care is.

The report also does not include the long term costs and outcomes of different birth types or models of care. Substantial, directly attributable costs beyond the intrapartum period exist, including NHS obstetrics litigation (£301m last year) and treatment of babies and mothers injured during even "normal, low risk" births—for example, brachial plexus palsy, trauma counselling, and pelvic floor surgery.

Identifying low risk pregnancies is also costly. The Netherlands has one of the worst perinatal mortality rates in Europe,[4] despite including gestational and weight limits in its "live birth" data, which does not happen in the UK.

I do not criticise midwife led care itself, but 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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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d2298

NEW DRUGS FOR HYPONATRAEMIA

Authors' reply

Grant suggests that tolvaptan could reduce hospital stay in acute neurosurgical patients,[1] 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.

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Competing interests: None declared.

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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.[1] 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.[2 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.[3] 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

exclude the role of potential confounders, but more clinically oriented studies using validated diagnostic instruments are needed to investigate whether or not cannabis increases the risk for psychotic disorders (which it probably does).

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1 Kuepper R, van Os J, Lieb R, Wittchen H, Hofler M, Henquet C. Continued cannabis use and risk of incidence and persistence of psychotic symptoms: 10 year follow-up cohort study. *BMJ* 2011;342:d738. (1 March.)
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Authors' reply

Diagnoses of psychotic disorder in the *Diagnostic and Statistical Manual of Mental Disorders* and *International Classification of Diseases* have poor validity and reliability, particularly in the context of general population studies, which is why the EDSP study focused on the full range of (attenuated) psychotic symptoms, combined with measures of functional impairment and help seeking.[1]

Unlike previous CIDI (composite international diagnostic interview) studies, interviews in EDSP were conducted by psychologists who were allowed to probe with follow-up clinical questioning. The focus on psychotic symptoms allowed analyses to be conducted on the earliest expression of psychosis, long before the onset of clinical disorder. This is highly relevant clinically. Population studies have shown that many adolescents experience transitory developmental expression of attenuated psychotic symptoms. In a minority, developmental expression of psychosis persists, increasing the risk for later onset psychotic disorder.[2 3] Understanding the process of persistence is the key to understanding the early development of psychotic disorder. Because of evidence that such persistence is associated with environmental exposures,[4] we aimed to examine cannabis in relation to persistence of the earliest expression of symptoms. Research in psychiatry is moving towards the earliest expression of risk in an attempt to intervene earlier; this paradigm urgently needs to be extended to the influence of environmental exposures such as cannabis.

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GPs AND CHILD PROTECTION

Online conferencing—not yet

I wonder whether Mills has tried the online conferencing for child protection that he proposes.[1] Over the past 20 years I have been involved in various synchronous discussions, using technologies ranging from post-it stickers 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.[2] Accounts of synchronous multi-user access were hard to come by, and the functionality was much less than a "traditional" child protection conference.[1] 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."[3] 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.[4]

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Competing interests: WC was involved in various online projects, including a shared access electronic database for vulnerable children funded by the Invest to Save Budget. He has also been involved in teaching for lead professionals supporting children with disabilities.

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MASS SHOOTINGS

Annie get your gun

JADSON MARQUES/AE/AP/PA

Former Coalition for Gun Control convenor, Simon Chapman, omits a crucial fact about mass shootings after Australia's 1996 prohibition of semi-automatic firearms and pump action shotguns.[1] Although Australia has not had a mass shooting in more than 14 years, neither has its close neighbour New Zealand. This observation cannot be attributed to pre-existing differences: the rate of 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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Competing interests: Dr McPhedran and Dr Baker are affiliated with the International Coalition for Women in Shooting and Hunting (WiSH). They receive no financial rewards from this association.

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