LETTERS

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HOSPITAL EPISODE STATISTICS

Garbage in, garbage out

As part of an educational initiative to support frontline staff to better understand the importance of accurately capturing and coding patient episodes, we reviewed freely available data from HESonline.[1 2] We found some interesting statistics.

On average, 1600 adults aged over 30 apparently attend outpatient child and adolescent psychiatry services in England each year (figure). Indeed, the number of adults attending outpatient paediatric services since 2003 has increased steadily, with a steep increase, to nearly 20 000, in 2009-10.[3] Adults over 60 are also being admitted to inpatient paediatric and inpatient child and adolescent psychiatry services.[3]

We are not clear why so many adults seem to be availing themselves of paediatric services, but it might be part of an innovative exchange programme with paediatric patients attending geriatric services. The number of 0-19 year olds attending outpatient geriatric medicine services has increased steadily, with over 3000 attendances in 2009-10 (figure). However, the number of inpatient admissions to geriatric medicine and old age psychiatry by 0–14 year olds has remained fairly constant.[3]

We were quite surprised to discover that many males seem to be attending outpatient obstetrics, gynaecology, and midwifery services.[3] Amazingly, between 2009 and 2010, there were over 17 000 male inpatient admissions to obstetric services and over 8000 to gynaecology with nearly 20 000 midwife episodes (figure).

These statistics seem to reveal some interesting service developments, but, although we applaud innovation, we suspect that the numbers may, at least partly, reflect data errors. Some of these may be due to similarities in the main specialty codes.[3]

How services in the NHS are commissioned is changing dramatically.[4] We hope that data will inform decision making during this process. Perhaps we should all examine the data being submitted by and about our services for unintentional innovation.

Lauren Brennan specialty doctor and honorary clinical research fellow
Lauren.Brennan@imperial.nhs.uk
Mando Watson consultant paediatrician
Robert Klaber consultant paediatrician
Tagore Charles consultant paediatrician, Imperial College Healthcare NHS Trust, Imperial College London, Paediatrics, St Mary's Hospital, London W2 1NY, UK

Competing interests: None declared.

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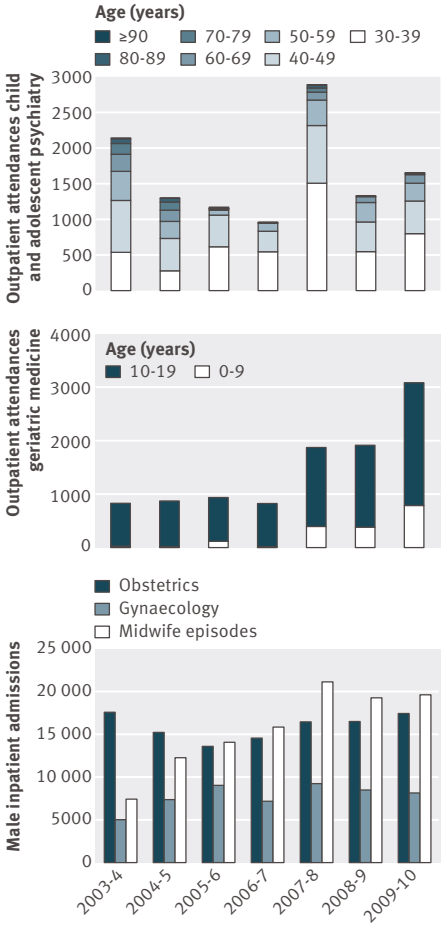

Top: Outpatient attendances to child and adolescent psychiatry by those aged from 30 to 90 and over. Middle: Outpatient attendances to geriatric medicine by those aged 0-19 years. Bottom: Male inpatient admissions to obstetrics and gynaecology, as well as midwife episodes

WEEKEND STAFFING AND MORTALITY

Correlation oversimplifies multifactorial problem

Like many trusts across the country, we were worried by Dr Foster's report of increased mortality at weekends and the correlation with reduced levels of medical staffing.[1] I routinely review the case notes of all patients who die, looking for learning points or systematic errors that could be rectified. Recently, I reviewed 53 consecutive deaths, specifically comparing weekday and weekend practice.

I looked at the time from admission to junior, middle grade, and consultant review. I identified cases across the week where time to review at all levels should have been shorter, but weekend practice was no different from that during the week. Goddard and Lees's point that patients admitted at the weekend were sicker than those admitted during the week was clearly shown. Twice as many patients admitted at the weekend than during the week had a modified early warning score of five or more. In addition, of the 53 deaths reviewed, four were in elderly highly dependent patients admitted from nursing homes when they were clearly dying. In each of these patients, who were all admitted at the weekend, only palliative measures were considered appropriate. Such treatment should have been available to these patients in their own beds without subjecting them to the trauma and discomfort of an acute hospital admission.

The correlation between senior medical input in hospital and weekend mortality oversimplifies a complicated and multifactorial problem. The problem of weekend mortality must be considered in the context of care provided to patients in the community and once they are admitted to hospital. Better provision of community out of hours services and improved end of life advanced care planning must be given equal weight to improving weekend hospital staffing and workforce configuration in hospitals.

Colin M A Wasson associate medical director, intensive care consultant, Stockport NHS Foundation Trust, Stockport SK2 7JE, UK
colin.wasson@stockport.nhs.uk

Competing interests: None declared.

1 Goddard AF, Lees P. Higher senior staffing levels at weekends and reduced mortality. *BMJ* 2012;344:e67. (10 January.)

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Use consultants only for critically ill patients

Using Dr Foster's publicly available relative risk data, my hospital also shows an association with increased mortality at weekends by age, length of stay, and certain comorbidities.[1] It is unclear without multivariate regression analysis that senior input is an independent predictor.

No doubt there will still be a clamour for consultants to be on site 24/7 as a result of this conclusion. The analysis categorised a senior doctor as ST3 (specialist trainee year 3) or above, even though ST3 is the most junior grade of registrar and traditionally only consultants or associate specialists are regarded as senior. As such, any rearrangements that stem from this analysis should concentrate on increasing members of staff ST3 or above rather than consultants alone.

In my experience, consultants drafted in at weekends are often asked to make discharge decisions on well patients, outlaid to non-medical wards, or asked to perform the unfocused "post take ward round" rather than see critically ill patients to whom a senior decision may make the difference between life and death, as Dr Foster's report intimates.

If more consultants are to be required in hospital outside of traditional working hours, please allow us to see genuinely sick patients (and hence teach the junior medical staff) and not be there just to tick boxes about meeting "seen by a consultant within x hours" targets.

Richard Ian Shepherd consultant in acute medicine, Mid-Yorkshire NHS Trust, Pinderfields Hospital, Wakefield WF1 4DG, UK richard@shepfamily.com

Competing interests: None declared.

1 Goddard AF, Lees P. Higher senior staffing levels at weekends and reduced mortality. *BMJ* 2012;344:e67. (10 January.)

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ANTIPSYCHOTICS IN NURSING HOMES

Education, guidance, equality are needed to address problem

McCleery and Fox's editorial on antipsychotic prescribing in nursing homes did little to advance either the understanding of or the solution to the problem.[1]

Firstly, hospitals are the source of the problem: they are where drug treatments are started and where primary care doctors gain their knowledge beyond evidence based medicine. Over the past few years we at Bupa have continually sought to reduce antipsychotic prescription in care homes, but no sooner have we had an impact on one cohort of patients than it is replaced by a new group of admissions. The problem has to be managed at source.

Secondly, guidance is limited when behaviour exceptionally requires control for the safety of the individual and those around him or her. Guidance in the *BNF*, for example, is inadequate to guide doctors. Additionally, restraint through high dose treatment is not distinguished from liberation from anxiety through very low doses of antipsychotic drugs, and guidance on preferred regimens or alternatives is lacking.

Thirdly, care homes are inadequately commissioned. I recently visited an excellent hospice whose cost was around £500 a day. Dementia care in a nursing home is often commissioned around £600 a week, and most patients are referred to care homes from hospitals whose costs are of a wholly different order. Although the variations in care home performance indicate some capacity for improvement, the inequalities need more than research.[2]

Clive E Bowman divisional medical director, Bupa Care Services, Bridge House, Horsforth, Leeds LS18 4UP, UK bowmanc@bupa.com

Competing interests: CEB is medical director of care homes with responsibilities in the UK, Spain, New Zealand, and Australia.

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Cite this as: *BMJ* 2012;344:e2421

Improve environment to reduce pressure to prescribe

McCleery and Fox say that the ethical concern about prescribing antipsychotic drugs to residents of nursing homes who have dementia is worthy of an editorial in itself.[1] Rarely do such patients ask to be treated: requests usually come from care staff. However, such requests do not result simply from a desire for a quiet life for staff. Nurses in such establishments often work with minimal staffing and comparatively little training and specialist support. They may claim and intend to practise person centred care, but the difficulty they deal with is having both to care for an individual resident and to allocate resources to all the other residents. The worst result is that individuals' wishes and their wellbeing may be over-ridden or perhaps not even considered.

The implication when writing about neuropsychiatric symptoms in dementia is that all odd behaviour is caused by the dementia. But the social and physical environment in which the person with the damaged brain lives must be considered. Macbeth remarked: "And that which should accompany old age,/As honour, love, obedience, troops of friends,/I must not look to have . . ."[2] Well, there is not much of that in most of the nursing homes I have visited, and social isolation, an unfamiliar environment, inactivity, and boredom are as likely to be relevant to the emergence of difficult behaviour as the underlying dementia.

A broader conceptualisation of what affects behaviour by everyone might reduce the pressure on reluctant doctors to prescribe antipsychotic drugs and increase pressure on care home providers and their funders to pay more attention to the quality of the environments and the levels of care they provide.

Paul Whitby clinical psychologist, Avon and Wiltshire NHS Trust, Green Lane Hospital, Devizes SN10 5DS, UK paulcwhitby@googlemail.com

Competing interests: None declared.

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2 Shakespeare W. Macbeth. Act V, scene III. http://nfs.sparknotes.com/macbeth/page_192.html.

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There is pressure to prescribe in learning disability too

My first specialist job in community old age psychiatry entailed frequent visits to nursing homes. Fortunately, my consultant was conscious of the clinical and ethical challenges of managing the behavioural and psychological symptoms of dementia, but even with such support I was often pressured by care home staff and sometimes relatives to prescribe something to "sort things out."[1]

My current job in community learning disability has similar challenges. Many patients live in care homes and are doubly disposed towards challenging behaviour—for example, patients with Down's syndrome have an increased risk of relatively early onset Alzheimer's disease, and learning disabilities may also be directly associated with challenging behaviour. They are thus at risk of staff seeking pharmacological answers to behavioural and managerial challenges. This frequently translates into requests for a prescription of something to help "calm the patient down."

Fortunately, in our team we have the support of a challenging needs specialist. However, there is only one specialist for several hundred

patients so prescription is sometimes required. Promethazine may be helpful because of its sedating properties, but often a low dose antipsychotic drug such as risperidone is chosen.

The evidence base for antipsychotics in challenging behaviour is limited, but the placebo effect in staff and carers may be large. Some of the risks associated with their use are likely to apply across patient groups—to patients with learning disabilities as well as those with dementia.

A further complication is that prescription is often decided on the grounds of a patient's best interests, and carers' assessments may be coloured by their experiences of struggling to manage challenging behaviour in an under-resourced environment. The doctor can be left wondering for whom they are prescribing and who is their patient.

Samuel Yates CT2 in learning disability psychiatry, Hounslow and Richmond Community Healthcare, Hounslow TW5 0LW, UK samuelyates@doctors.org.uk

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1 McCleery J, Fox R. Antipsychotic prescribing in nursing homes. *BMJ* 2012;344:e1093. (23 February.)

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PHAEOCHROMOCYTOMA

Interpret metanephrine results in light of clinical indications

Jones and colleagues highlight the importance of making the diagnosis of phaeochromocytoma.[1] We support their approach of initially undertaking biochemical investigations, but they do not deal clearly with sampling, patient preparation, and clinical indications for the test, which are essential for interpreting results.

Metanephrine concentrations should be interpreted differently in patients with rare genetic predisposition syndromes (such as multiple endocrine neoplasia (MEN) type 2; mutations of succinate dehydrogenase genes, *SDHx* and *SDHD*; and neurofibromatosis 1) than in those with symptoms. Such patients can have a prevalence of phaeochromocytoma of up to 50% and are often included in surveillance programmes. In this situation, borderline positive values (or a rising trend within the normal range) should trigger extra tests. Tumours of less than 1 cm may produce insufficient amounts of catecholamines to be detected biochemically.[2] Conversely, positive values should be interpreted carefully in light of possible interfering drugs (even simple drugs such as paracetamol). Recently, venlafaxine was reported to produce a false positive result in a patient with an *SDHB* mutation.[3]

Careful interpretation of metanephrine results is also warranted in patients with incidentalomas—masses, generally more than 1 cm in diameter, discovered during a radiological examination (often computed tomography) not undertaken for evaluation of adrenal disease.[4] We have seen extra-adrenal phaeochromocytomas with large cystic components and metanephrine results persistently in the borderline range. The pretest probability of phaeochromocytoma or paraganglioma is higher in the presence of an adrenal incidentaloma. Particular care should be taken when interpreting borderline results if there are cystic features on imaging. Previous cases have shown negative results on biochemical evaluation.[5]

Stewart J Pattman chemical pathology/metabolic medicine specialist registrar, Department of Clinical Biochemistry, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP, UK stewart.pattman@nuth.nhs.uk
Andrew Davison principal clinical biochemist, Department of Clinical Biochemistry, Freeman Hospital, Newcastle upon Tyne, UK
Steve Ball consultant endocrinologist, Department of Clinical Biochemistry, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP, UK

Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e2456

FIELD OF PLAY RESUSCITATION

Do not move player until return of spontaneous circulation

The recent case of the footballer who had a sudden cardiac arrest on the football pitch highlights key points regarding field of play resuscitation.[1] The decision about when to move patients from the field of play, particularly if they remain in cardiorespiratory arrest, is crucial. Effective continuous chest compressions are closely correlated to survival—even an interruption of only a few seconds can be detrimental.[2] A high "hands on the chest ratio" allows coronary perfusion pressure to increase, improving the chance of successful defibrillation.[3]

Recent research has shown that effective manual chest compressions cannot be performed while moving a patient on a stretcher

GETTY IMAGES

or in an ambulance.[4] Ambulance personnel are now encouraged not to move a patient in cardiopulmonary arrest, particularly in a shockable cardiac rhythm (ventricular fibrillation/pulseless ventricular tachycardia) until return of spontaneous circulation has been achieved or prolonged resuscitation efforts have failed.

A cardiac arrest on the field of play is a high profile incident with many onlookers. There will be pressure to move the patient early to maintain privacy. Sports medical teams must be confident in performing uninterrupted resuscitation on the field of play. Provision of privacy on the field of play would reduce pressure to move the patient and maximise the chance of survival.

Richard M Lyon registrar in emergency medicine and pre-hospital care, Surrey Air Ambulance, Cranleigh GU6 8TB, UK richardlyon@doctors.org.uk
Caroline Wiggins general practice specialty trainee and postgraduate student, Faculty of Sports and Exercise Medicine, Queen Mary University, Mile End Hospital, London, UK

Competing interests: None declared.

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HEALTHY AGEING

Minimise sedentary behaviour

Myint and Welch fail to do justice to the first UK-wide recommendations for physical activity.[1 2] They neglect to mention the most novel aspect of these recommendations—that long periods of being sedentary should be reduced at all ages. Sedentary behaviour is not a lack of physical activity but an umbrella term for behaviours where sitting or lying is the dominant

mode of posture and energy expenditure is very low. It is an independent risk factor for health and wellbeing. In other words, long periods of sitting have deleterious effects on health and wellbeing even in people who meet the recommended guidelines for physical activity.

Currently these recommendations cannot be more precise because the dose-response association is not known.[2] Most research has focused on sedentary behaviour in children,[3] even though older adults are the most sedentary segment of society.[4] It is hard to believe that all periods of sitting are deleterious to health, so efforts to develop a classification system and better sensing methods need to be an integral part of refining guidelines.[5]

Sebastien F M Chastin senior research fellow in behaviour dynamics sebastien.chastin@gcal.ac.uk
Dawn A Skelton professor of ageing and health, Glasgow Caledonian University, School of Health and Life Sciences, Institute of Applied Health Research, Glasgow G4 0BA, UK

Competing interests: None declared.

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Cite this as: *BMJ* 2012;344:e2451

DEATHS FROM SMOKING

Overseas health professionals should lobby their governments

Delamothe develops the case against British American Tobacco (BAT) and Imperial Tobacco, our leading cancer exporters.[1]

As he notes in a rapid response addendum,[2] it seems that the diplomatic service is still batting for BAT, a clear breach of UK obligations under the Framework Convention on Tobacco Control.[3]

Overseas readers, particularly in lower and middle income countries, should lobby their governments directly and via their professional organisations, with the aim of having ministers challenge UK ambassadors. Ministers should ask what the UK government intends to do about the activities of these cancer exporting tobacco companies that are creating a 21st century tobacco holocaust for the developing world that will dwarf that of the 20th century.

Stewart N Brock public health specialist, Taunton TA2 6LR, UK stewartbrock@tiscali.co.uk

Competing interests: None declared.

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THE UNRAVELLING NHS

Instead of jumping up and down we must propose alternatives

Undoubtedly, the Health and Social Care Bill is a very bad bill,[1] but we must reflect on where we are at the moment. The current system of primary care trusts and acute trusts has already grossly fragmented the NHS. Many doctors spend endless hours generating policies and formularies that are just slightly different from those of the trust next door.

We are familiar with the farce of "commissioning." We see impediments to internal referrals purely because of funding streams. Most issues of *Private Eye* contain cases of iniquitous treatment of doctors by trusts, which lead to months or years of "investigations." The victims are usually vindicated and the taxpayer foots the bill. Trusts have acquiesced blindly to the European Working Time Directive, at great cost and clear damage to the continuity of patient care and the quality of clinical training. We are approaching revalidation, a system with no evident validity. It is meant to "reassure the public," but no lay person to whom I mentioned it had a clue what it was about. They can see that the tragedy of Shipman would not have been prevented by this process; indeed, he would probably have been one of the "responsible officers."

Our profession is jumping up and down having found most of the stables empty but is not proposing alternatives. Just saying we need "more resources" does not do the job.

Michael Schachter senior lecturer in clinical pharmacology, Imperial College London, St Mary's Hospital, London W2 1NY, UK m.schachter@ic.ac.uk

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1 Hunter DJ, Williams GH. NHS "reform" in England: where is the public interest? *BMJ* 2012;344:e2014. (14 March.)

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Reform is a one way road

The contrast between attempts at healthcare reform in the UK and US is disturbing. Despite President Obama's popularity and the undisputed fact that the US healthcare system is in need of reform, it has been a struggle for him to pass even the diluted version of his original bill, a version that many argue fails to deal with the fundamental problems that plague the system. In contrast, a UK coalition government that stumbled into power has the audacity to push through reforms that will tear apart the very fabric of an effective universal healthcare system.[1] A multi-tier system already exists in the US and is difficult to change because so many groups benefit financially. Once a similar situation arises in the UK, which the current healthcare bill undeniably paves the way for, it will be challenging indeed to return to an NHS that is universal in more than just name.

Adam M Ali Frank Knox fellow, Harvard University, Cambridge, MA 02138, USA adamali@post.harvard.edu

Competing interests: None declared.

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Private partners have a different ethos from the NHS

I was surprised last month when a "choose and book" referral to a local private hospital for someone who needed minor surgery was rejected because the patient had a history of drug misuse.

The NHS has a long history of "socialist" principles and has striven to provide services that are accessible to all. It seems that our new private partners do not have the same ethos.

I fear that this is a premonition of the future of healthcare in this country, and I wonder how the Liberal Democrats who supported the bill last month will be able to explain their actions to their electorate.[1]

Tony M Hirst general practitioner, Blackburn with Darwen PCT, Darwen Health Centre, Darwen BB3 1PY, UK tony.hirst@nhs.net

Competing interests: None declared.

1 Godlee F. Prophesying doom [Editor's Choice]. *BMJ* 2012;344:e2070. (15 March.)

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