opportunities to observe the family as a whole. Nevertheless, a successful surveillance programme can be provided by health visitors only if they receive continuing professional education and support in all aspects of child development. Close working relationships with individual general practitioners and community paediatricians would be essential. The general practitioner would accept responsibility for the organisation of child health surveillance within the practice and would offer advice or arrange referrals as appropriate.

What training should be required of general practitioners who wish to participate in child health surveillance? A national consensus has yet to emerge on this issue. It is doubtful whether any existing postgraduate qualification is sufficient evidence of the necessary knowledge and skills. Perhaps certification could be arranged as an option during vocational training, as is already the case with family planning. Despite the present uncertainty, however, three requirements may be identified.

Firstly, though general practitioners do not need to undertake developmental examinations, they must have some insight into the process of child growth and development and the problems that affect it. Perhaps more important are respect for the anxieties raised by parents and other professionals and readiness to refer children promptly for more expert assessment. The training requirement could be fulfilled by private study and suitable short courses. Secondly, many general practitioners will also welcome individual instruction in physical examination techniques and in normal child development. This training can most conveniently be offered by local clinicians. The third essential is a detailed statement of the surveillance policy adopted by each individual health authority or board. This should be accompanied by information about the optimal referral pathways for children with suspected developmental or health problems.

The new contract recognises that general practitioners will need to supply information about which children have been examined so that the surveillance programme can be monitored in each health district. Few districts have the means to do this; and though "information technology" offers various solutions, all require substantial planning and investment. No doubt specialists in community medicine and directors of public health will wish to take part in these developments.

What is the future for community child health doctors? As not all general practitioners will wish to offer a child health surveillance service, many parents will continue to attend community clinics for checks and advice, particularly in socially deprived areas, where the standard of general practice is sometimes low. The need for these clinics will, however, probably diminish as more general practitioners take up the challenge of practice in these areas.

Only a few general practitioners will have either the desire or the opportunity to become expert in diagnosing developmental disorders. Community doctors, who have a wider experience of child development and behaviour, should therefore extend their consultative role, but they will need further training, better supervision, and greater credibility. These improvements are most likely to be achieved if community doctors have a consultant led service, a planned career structure, and a closer association with hospital departments of child health.

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Patients with spinal injuries

Early transfer to a specialist centre is vital

In the past 50 years the greatest advance in managing patients with spinal cord injuries has been the establishment of trauma services for the complete care of such patients. Most spinal injuries units in Britain, however, developed with no account being taken of national planning. As a result their distribution is far from ideal and some areas (such as Kent) remain ill served.[1] Ideally, patients with spinal injuries should be admitted to the nearest unit within 24 to 48 hours of their accident, but this is not always achieved.[2,3] The opening of the Duke of Cornwall Spinal Treatment Centre in Salisbury in January 1984 provided the stimulus for us to look at the pattern of treatment and transfer of such patients in the south and south west of England.

No clear guidelines have been agreed for optimum management, and consequently some patients have experienced considerable delay in admission to the centre. Only 37% of patients who had been treated conservatively and 4% of those who had undergone a stabilising operation before transfer were admitted to the centre within 48 hours after injury. In those who had been operated on the commonest reasons for delay were related to spinal operations and their complications (36% of patients). Nine per cent of patients underwent multiple transfers, being moved firstly to a hospital where spinal surgery was available and then to the spinal treatment centre.

One of the serious complications caused by the delay was the development of pressure sores. No sores were seen in patients admitted within 48 hours after injury, but if transfer was delayed by eight days or more the incidence of pressure sores was 14% in patients who had been treated conservatively and 29% in those who had had an operation.

Other complications of operations were also common. Some of these were the result of inappropriate treatment that was given because doctors, often failed to understand the pathophysiology of the injury, and others resulted from technical failure—inadequate bone grafting or inappropriate spinal instrumentation. Thirdly, some problems seemed to be due to lack of skills in the use of spinal instrumentation. These technical failures made a further operation necessary in 15 out of 77 patients (19·5%).

Our analysis of all of the patients who had both primary and revision operations in the spinal treatment centre showed a rate of complication of zero. These patients were treated by rigid spinal immobilisation by using either a posterior approach with interspinous wiring in the cervical spine or square ended contoured Harrington rods with bifid upper hooks in the thoracic and thoracolumbar spine. Every patient had extensive bone grafting and was supported postoperatively in a firm cervical collar or brace. Only one patient asked for the internal stabilisation device to be removed because of an extremely active lifestyle. No patient deteriorated neurologically after surgery, but neurological benefit was not analysed—the numbers were too small and no attempt was made to randomise treatment.

We believe that if surgeons are to avoid the many potential pitfalls in operating on patients with acute spinal injuries the initial appraisal should be made a by team of doctors who are fully conversant with the modern techniques of stabilisation and instrumentation. Doctors at the district hospital where the patient is treated initially should, we believe, consult with the nearest supraregional spinal unit so that joint decisions

can be made about initial management and transfer of the patient to the specialist centre.[4]

Early transfer is desirable for virtually all patients. For example, the spinal unit in Perth, Western Australia, succeeds in admitting 91% of patients within 24 hours and 95% within 48 hours.[3] The figures in Britain fall seriously short of this ideal. If we are to improve our results all spinal units should have direct access to the facilities of a district general hospital with an intensive care unit and an orthopaedic surgeon, a neurosurgeon, and a urologist, all with training in spinal injuries.[5] A plastic surgeon and maxillofacial surgeon should also be available as patients often have multiple injuries.[4]

The spinal unit must always be in a position to admit patients promptly; a better geographical distribution of beds would help. For patients with major trauma early admission may be life saving, and this may be best achieved by rapid transfer by helicopter to the most appropriate hospital.[6] In Switzerland the introduction of a nationwide helicopter rescue system for patients with spinal cord injuries reduced overall mortality by 80%.[7] Initiatives of this kind are needed if we are to reduce the rate of complications and achieve optimum management for our patients.

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The NHS bill

Doctors, nurses, and others still unconvinced

"Our recipe for the NHS is more taxpayers' money, less waste of that money, and a better service for the patient."[1] That was the way that Mr Kenneth Clarke introduced the National Health Service and Community Care Bill last week (p 1355), and no one would quarrel with his objectives. So why is the legislation opposed not only by the BMA but also by the royal colleges, the universities, the Royal College of Nursing, and the health service unions?

The central objection is to the underlying theory. The government has made no secret of its belief that in health care as in every other aspect of society it wishes to see competition between the private sector and the state funded service and that it also intends to promote competition within an internal market in the NHS. Most British doctors oppose this approach—and they do so on the basis of the experience of other countries. Whenever and wherever medical care is fragmented with a few centres of excellence and a basic service for the mass of the population the care provided by the mass service tends to become second rate. This was the case in Britain before the NHS—perhaps the most important achievement of which was to raise the standard of medical care in former local authority hospitals. Within Europe the best overall health care is provided by those countries with uniform systems used by all their citizens. The anxiety among health professionals in Britain is that much of the NHS hospital service may be reduced to providing safety net medicine while a few flagship institutions become ever more successful. Nowhere in the world is there an effective national health care system of the pattern proposed by the government; the medical and nursing professions know this and their apprehension is based on that knowledge.

Their other reasons for doubt are more down to earth. Mr Clarke promises "more taxpayers' money." The "extra £2.6 billion" announced for the NHS in the autumn statement caused problems for health service economists as they tried to work out how much actual extra money there would be—when account was taken of inflation, NHS inflation, savings not yet achieved, and the cost of the NHS review.[2] A sensible guess is that £500 million will be available for extra patient care—but as has been said so often before the NHS needs around 2% more money each year to cope with demographic change and technical innovations.[3]

Mr Clarke talks about less waste and greater efficiency. The internal market that will be created when the bill becomes law will require a vast and complex system of record keeping and accounting. This will take some years to get into action. Around 3500 more staff will be needed, many of them with skills in accounting and information technology. In recruiting these staff—and this applies to all NHS staff from secretaries to porters, from electricians to kitchen workers—the NHS has to compete with the rest of the labour market, and the rates it can offer are mostly non-competitive. There must be serious doubts that the NHS will be able to find and keep the staff it needs in the coming years. Possibly a few hospitals run by NHS trusts (opting out is no longer an acceptable phrase) may be able to pay rates that will attract first class workers, but most will have to continue to hope that people will be willing to accept low pay because they think the job worth doing. But the tradition of giving a lifelong unquestioning loyal service to the NHS has gone.

The third reason for professional doubt is that patients seem unlikely to gain from the breakneck speed at which everything seems to need to be done. Many of the new ideas—from internal markets to fund holding practices (another mollifying change in wording)—might well prove innovative, stimulating, and possibly money saving. But why the hurry? Why not try, test, and evaluate these projects and only then decide whether to restructure and redesign an organisation with one million employees?

The bill will be debated and analysed clause by clause in the coming session. The government should remember that the opposition of NHS staff to its proposals is not Luddite, nor is it politically motivated, nor is it irrational. NHS doctors and other staff are committed to the service and want it improved.

But any large organisation that plans a programme of major changes has three requirements; firstly, there must be a clear, detailed plan; secondly, a majority of the workforce must be committed and enthusiastic; and, thirdly, enough money must be available to lubricate the changes. On these criteria the NHS looks to be facing a depressing and testing time.

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