

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Waiting for child care

SIR,—I studied the outcome in children referred as emergencies to the children's hospital from 1 December 1989 to 31 January 1990. In all, 4563 children were seen in the accident and emergency department, of whom 562 required admission. On average 18 of a total of 110 beds were closed during this period: 10 closures were planned because of Christmas, seven because of overspending, and one because of nursing shortages. Consequently, 40 of the patients requiring admission had to be transferred elsewhere. A further 54 patients referred by local general practitioners for admission were unable to be accepted, making a total of 94 refused admissions. The situation was undoubtedly aggravated by the influenza outbreak, causing a relatively high incidence of illness among staff and children.

No information was available about the outcome for the 54 children referred by general practitioners. But the emergency beds service is available to help general practitioners with finding a place for their patients. When a patient arrives in a hospital accident and emergency department the care of the patient becomes that hospital's responsibility. Of the 40 patients transferred, 24 were aged less than 1 year and three were less than 1 month. Twenty one of the 40 families had given a telephone number when registering, and 15 were able to be contacted and spoke sufficient English to answer a short series of questions. Seven of the 15 sets of parents had waited more than three hours for their child to be seen initially. By the time the transfer had been arranged and they had arrived at the accepting hospital many of them had experienced a total delay in excess of five hours. Five of them thought that the delay and transfer had made their child appreciably more ill. Eight had experienced difficulty in visiting their child because they had been transferred to hospitals some distance away; one boy's parents were unable to visit him for five days because of the difficulty in travelling. It was surprising that 10 out of the 15 sets of parents were satisfied with the care that their child had received. Although the waiting and transfer had been inconvenient, they felt that everything possible had been done. Only two parents were extremely dissatisfied and wanted to complain. They felt that it was disgraceful that they had had to wait so long and then been sent elsewhere. One mother said that she would never bring her child to the hospital again. Fortunately, all of the children whose families I contacted had made an uneventful recovery.

Though 4563 children were seen in the accident and emergency department during the two months, many parents voted with their feet: 151 were not prepared to wait to be seen, and many went to other hospitals. The amount of registrar time spent arranging transfers was estimated at 50-100 hours, during which time they were obviously unable to

look after inpatients. Many hours were also spent by the hospital administrators and nursing staff arranging bed cover. All of the doctors involved were concerned that patients who should have been admitted for observation had been sent home. It may be argued that if children can be sent home and reviewed by the hospital or general practitioner then this is preferable to admission. There must be some truth in this, but there must also be an increased risk of patients who would have been admitted for observation if beds had been available becoming dangerously ill. Clearly there is very little leeway in a system that is stretched to the limit during normal activity.

This crisis is not confined to one hospital; with increasingly tight financial budgets and the nursing shortages destined to get worse we must consider if our current practice is the safest and most efficient way to care for our patients.

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What do hospices do?

SIR,—The article on hospice clinical activity by Dr Ian S Johnson and colleagues is interesting but flawed by an erroneous conclusion.¹ The new specialty of palliative medicine was pioneered by perceptive and compassionate nurses, doctors, and other professionals who did not enjoy the luxury of a formal training structure. Its "newness" is imposed by educational bodies who have recognised that professional training is still deficient in this part of professional caring, which is essentially a mixture of science, compassion, and humility.

These "non-technical professionals" created centres of inquiry and portrayed dedication and perseverance in caring for chronically and terminally ill patients in whom the developing NHS and its existing specialties showed little interest. Their inspired work identified the knowledge, skill, and attitude that are now being adopted by those building a new empire by moulding it into a professional specialty. To call those who laid the foundation "enthusiastic amateurs" is patronising and even insulting. Their enthusiasm was so well directed and creative that they attracted national and international attention in a comparatively short time. They gathered around them a growing body of multidisciplinary professional carers, whose conviction induced them to leave the security of employment in the statutory services, where they had already been recognised as professional. They were no less "professional" and no more "amateur" by being in the van of an aspect of caring that is now being "professionalised."

To be worthy successors of the so called enthusiastic amateurs the new accredited hospice consultants will need to exchange the exercise of

professional power for the notion of service. This exchange is demanding a great deal of further professional training, which usually hardens prosaic professional attitudes. Let us hope that the predicted displacement of the pioneer types will not result in the sort of technical care that renders the hospice indistinguishable from the hospital.

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1 Johnson IS, Rogers C, Biswas B, Ahmedzai S. What do hospices do? A survey of hospices in the United Kingdom and Republic of Ireland. *Br Med J* 1990;300:791-3. (24 March.)

SIR,—In their survey of hospices Dr Ian S Johnson and colleagues express surprise that "about a third of hospice home care services do not include a doctor on the team and many do not provide 24 hour cover and weekend cover." The most effective home care teams are those that work in harmony with the prime professional carers in the home—the general practitioner and district nurse. To suggest that a hospice nurse or doctor should be available at every hour of the day and night is to demean the high standard of palliative care provided by the primary health care team. Palliative care should be planned care; most crises can be anticipated and genuine emergencies are rare. General practitioners and district nurses are best equipped to deal with any such emergency and should be the professionals of first contact for the patient and his or her family. Provision of 24 hour cover has implications for the hospice home care team. Many teams are small, and continual availability, with its unavoidable stress, is destructive of hospice staff. Nurses and doctors need time away from their work, especially in hospice medicine, which can attract particularly conscientious staff.

Dr Johnson and colleagues predict the emergence of "accredited hospice consultants" who will displace the "enthusiastic amateurs" of the past. I hope that their forecast is wrong. There will be a place for large teaching hospices, where research, education, and clinical care will flourish. But such institutions can never cope with the large number of patients who need palliative care. To suggest that palliative medicine should be the preserve of the specialist is to de-skill the very people who are in the best position to provide it—primary health care teams. The way forward for palliative care entails recognition of the key role of the general practitioner and district nurse. Hospice care demands a team approach and depends not only on technical medical competence but also on the personal qualities of the staff. Patients with cancer and their relatives appreciate the unique contribution made by the "enthusiastic amateurs." Perhaps those seeking academic recognition for palliative medicine as a specialty would be wiser to acknowledge the work of the "enthusiastic amateurs,"

to enlist their support, and to encourage their continued participation in this branch of medicine.

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- 1 Johnson IS, Rogers C, Biswas B, Ahmedzai S. What do hospices do? A survey of hospices in the United Kingdom and Republic of Ireland. *Br Med J* 1990;300:791-3. (24 March.)

SIR,—We would like to make two points about the paper on hospices by Dr I S Johnson and colleagues.¹

Firstly, although the Royal College of Physicians has deemed palliative care a new specialty, it will be a good few years before sufficient senior registrar posts are established to satisfy the number of consultant posts becoming vacant. It is both necessary and desirable therefore that "enthusiastic amateurs" continue to provide a service. The role of the general physician in palliative care is well established; the general practitioner, effectively a community based general physician, with a special interest in palliation is also in an ideal position to orchestrate such care.

These sentiments were forwarded 25 years ago by Wilkes, who found general practitioners to have "great shrewdness and experience in this field."²

Increasing specialisation of what we believe to be basic medical skills is unfortunate: many clinicians have much to contribute to palliative care. The arbitrary distinction between those perceived to have had formal training in palliative care and those who have not causes an unnecessary and inevitable hierarchical polarisation. More importantly, evaluation studies will identify those units which are failing to meet the needs of the local community, irrespective of the postgraduate qualifications of the medical staff.

Secondly, the paper gave few details on the patients for whom the hospices catered, and we suspect that there would have been great variation in the populations served. Until there is convincing evidence that all appropriate groups of patients—for example, those with HIV disease—have access to palliative services it would seem reasonable that any unit—whether staffed by accredited consultants or enthusiastic amateurs—attempts to respond to what is appearing to be a genuine need.

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- 1 Johnson IS, Rogers C, Biswas B, Ahmedzai S. What do hospices do? A survey of hospices in the United Kingdom and Republic of Ireland. *Br Med J* 1990;300:791-3. (24 March.)
- 2 Wilkes E. Cancer outside hospital. *Lancet* 1964;i:1379-81.

Management of patients with head injuries

SIR,—We share Mr S C Brooks's concern regarding the lack of availability of neurosurgical facilities for patients with injuries.¹

The problems that he and our neurosurgical colleagues in the South East Thames region face are, unfortunately, commonplace. We frequently have to accept ventilated patients when we do not have any vacant intensive therapy beds on a "sale or return" basis. It is only as a result of the dedication and cooperation of our nursing and medical colleagues that we are able to admit many of the patients with head injuries who are referred to this unit from both North East and North West Thames regions. Not infrequently we are asked to accept patients who were initially destined for transfer to other neurosurgical units that have, during the transfer, become unable to cope

because of restricted facilities. We have also, on occasion, had to transfer our own ventilated patients to other neurosurgical and non-neurosurgical intensive care units.

One possible solution that has been proposed is the establishment of a bed bureau system along the lines of that currently in use for neonatal cases. This is neither ideal nor acceptable when transfer across London may add two hours to transfer time.

We urge that, excellent as they are, the adoption of the South East Thames Regional Health Authority guidelines² takes second place to the provision of adequate facilities in all hospitals with neurosurgical units. As the expectations of the public and skills of the carers escalate, the provision of adequate facilities becomes of paramount importance. Our intensive care unit has to meet the requirements of a district general hospital and specialist services, including neurosurgery and liver transplantation services, with an inadequate total of seven beds. We ask that all concerned, at referring and receiving units alike, continue to emphasise the importance of ensuring the availability of neurosurgical intensive care facilities to those who are in a position to remedy the current inadequacies.

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- 1 Brooks SC. Management of patients with head injuries. *Br Med J* 1990;300:876. (31 March.)
- 2 Anonymous. Notes. *Br Med J* 1990;300:546. (24 February.)

Lipid lowering drugs

SIR,—In a recent review article on lipid lowering drugs Dr Patricia O'Connor and colleagues state that pravastatin seems to be more tissue selective than simvastatin.¹ This statement is based on in vitro and ex vivo animal data.^{2,3} In vivo studies of tissue distribution in rats have, however, shown that 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitory activities in peripheral tissues (kidney, spleen, testes, stomach, and adrenal glands) after oral simvastatin and lovastatin are three to six times lower than those after pravastatin.⁴ On the other hand, the inhibitory activity in the liver after pravastatin was 50% of that after either simvastatin or lovastatin. Merck Sharp and Dohme chose to develop the lactone forms of lovastatin and simvastatin because they are preferentially taken up by the liver—the principal organ for cholesterol synthesis—and converted there into their bioactive hydroxyacid forms.⁵

More importantly, clinical experience, which is substantial with simvastatin and lovastatin (about 20 000 patients have been treated in clinical trials for up to five years and two million in worldwide marketed use), indicates that these drugs are well tolerated,^{6,7} but the use of pravastatin has been much more limited. The important adverse effects of this class of drugs—they raise liver transaminase activities and cause myopathy—occur with all three drugs. These adverse effects are uncommon and there is no evidence that they are less frequent with pravastatin.

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- 1 O'Connor P, Feely J, Shepherd J. Lipid lowering drugs. *Br Med J* 1990;300:667-72. (10 March.)
- 2 Tsujita Y, Kuroda M, Shimada Y, et al. CS-514, a competitive inhibitor of 3-hydroxy-3-methylglutaryl-coenzyme A reductase: tissue selective inhibition of sterol synthesis and hypolipidemic effect on various animal species. *Biochem Biophys Acta* 1986;877:50-60.
- 3 Mosley S, Kalinowski S, Schafer B, Tanaka R. Tissue-selective

acute effects of inhibitors of 3-hydroxy-3-methylglutaryl coenzyme A reductase on cholesterol synthesis in lens. *J Lipid Res* 1989;30:1411-20.

- 4 Gemershausen JJ, Hunt VM, Bostedor RG, et al. Tissue selectivity of the cholesterol-lowering agents lovastatin, simvastatin and pravastatin in rats in-vivo. *Biochem Biophys Res Comm* 1989;158:667-75.
- 5 Duggan DE, Chen IW, Rosegay A, Ellsworth RL. Hepatoselectivities of simvastatin and pravastatin: direct measurements of drug and metabolites in dogs and rats. *Biochem Biophys Res Comm* (in press).
- 6 Walker JF. Simvastatin: the clinical profile. *Am J Med* 1989;87 (suppl 4A):44-6.
- 7 Tobert JA, Shear CL, Chremos AN, Mantell G. Clinical experience with lovastatin. *Am J Cardiol* 1990;63:23-6F.

AUTHORS' REPLY,—In the statement referred to by Drs Tomás S Bocanegra and Jonathan A Tobert we chose the term "seems" because it is a non-definitive term. Available studies are not strictly comparable and are open to various interpretations.^{1,2}

Chemical studies have shown that pravastatin is several times more water soluble than simvastatin and lovastatin. Consequently it may be preferentially taken up by the liver. Unfortunately, measurements of hepatic concentrations are confounded by the fact that these drugs are converted to metabolites that have differential activity as inhibitors of 3-hydroxy-3-methylglutaryl coenzyme A reductase. In addition, these drugs and their metabolites bind to tissue proteins, which may cause their differential inactivation. Thus methods that measure inhibition of the enzyme after disruption of the tissue may not reflect the true biological state.

Additional useful information may evolve when direct chemical measurements of these drugs and their active metabolites are available. If, as seems to be the case, however, several active metabolites exist this may prove difficult. The absolute answer to the question of the tissue selectivity of hydrophobic and hydrophilic 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors must remain moot.

Whether or not tissue selectivity of these drugs has any real biological importance in terms of differential toxicity is unknown. We must await the outcome of continuing long term postmarketing surveillance studies. As stated in our review, studies on the clinical efficacy of the 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors show all three drugs to be equally efficacious as hypolipidaemic drugs. In addition, adverse effects are not known to occur more frequently with any one of the three drugs.

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- 1 Gemershausen JJ, Hunt VM, Bostedor RG, et al. Tissue selectivity of cholesterol lowering agents lovastatin, simvastatin and pravastatin in rats in-vivo. *Biochem Biophys Res Comm* 1989; 158:667-75.
- 2 Tsujita Y, Kuroda M, Shimada Y, et al. CS-514, a competitive inhibitor of 3-hydroxy-3-methylglutaryl coenzyme A reductase: tissue selective inhibition of sterol synthesis and hypolipidaemic effect on various animal species. *Biochem Biophys Acta* 1986;877:50-60.
- 3 O'Connor P, Feely J, Shepherd J. Lipid lowering drugs. *Br Med J* 1990;300:667-72. (10 March.)

General practitioner obstetrics in Bradford

SIR,—The recent paper¹ and correspondence about intrapartum obstetric care by general practitioners in Bradford should be taken as the starting point of a debate about a nationwide problem. Above all we should not be left with the idea that the difficulties of Bradford are in any way unique or atypical.

The unpalatable truth is that intrapartum care