Swimming and grommets

Children with grommets should be allowed to swim

Nearly 40 years after the technique of grommet insertion was reintroduced by Armstrong[1] otolaryngological advice about whether children with grommets should be allowed to swim still varies from total prohibition to total licence. The theoretical risk is that water will pass through the grommet and infect the middle ear. But does this happen?

Morgan found that after the ears were submerged in a bath for four minutes in only half the cases was there water on the tympanic membrane.[2] Calculating that water pressures of 12·5-22·5 cm would be needed to push water through a grommet, several authors concluded that contamination of the middle ear was unlikely with normal swimming, hair washing, and bathing but that the risk would be increased with diving.[3,4] They suggested that the eustachian tube had to be functioning before water would pass though a grommet,[5] and Myerhoff *et al* confirmed this with animal experiments.[6] Children with glue ear often have impaired function of the eustachian tube, thus making contamination of the middle ear less likely.

If water passes through a grommet does it matter? Over three weeks Smelt and Monkhouse irrigated the middle ear mucosa of guinea pigs with sea water, bath water, swimming pool water, or normal saline (as a control).[7] Only bath water provoked appreciable inflammation.

In the first prospective trial comparing patients fitted with grommets who did and did not go swimming Chapman found that the rate of otorrhoea was lower in those who swam without using ear plugs than in non-swimmers (14% *v* 18%).[8] Since then six further papers have compared rates of infection between swimmers and non-swimmers and found no significant difference.[9-14] As in Chapman's original study five of these papers reported a lower incidence of otorrhoea in swimmers than non-swimmers. Ear plugs seem to confer no extra benefit, and the muffling of sound and the necessary adult supervision decrease both the fun and the enjoyment of swimming.[15] The question of whether bath water increases the risk of ear infection in children with grommets has not been studied, though high concentrations of bacteria and irritative substances have been shown in bath water.[16]

Chapman wrote that the advice to forbid swimming in children with grommets "causes distress, delays the acquisition of a life-saving skill and is based on no published evidence."[8] Twelve years and numerous studies later, this statement remains true.

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Fiddling with medical negligence

Forget arbitration and go for no fault

Britain's system of responding to medical accidents is slow, expensive, inefficient, capricious, and hard to understand. It fails to compensate most of those who are injured[1,2] and does almost nothing to reduce the likelihood of the accidents recurring. Lord Pearson's commission recognised most of these faults in the 1970s,[3] and it is increasingly hard to find anybody who will speak up for the system. The main alternative to tort is a no fault system, and support for such a system has come from many groups and individuals including the BMA,[4] the chairman of the Law Commission,[5] and members of parliament Rosie Barnes and Harriet Harman.[5]

The government has always held out against the pressure. But the Secretary of State for Health has proposed the introduction of a voluntary system of arbitration in cases of medical negligence to supplement, not replace, the tort system.[6] The proposal has the advantage to him that he will be seen to be doing something, but it will make minimal impact on the real problems.

The Department of Health may recognise the flimsiness of the solution because in its consultation document it never attempts to define the problem. Instead, it leaps into the details of the scheme. The proposal—borrowed from Lord Griffiths, the law lord[7]—is that rather than go to court both parties would voluntarily submit to arbitration by a panel of two doctors (one nominated by each party) and a lawyer skilled in medical negligence. The panel would work mostly on paper and would apply the same standard of negligence as the courts—that is, that the treatment of the patient was not in accordance with a responsible body of medical opinion. The majority view would prevail, but the lawyer's views would carry greater weight on points of law. The panel could award damages as large as in the courts, and there would be no appeal to the courts except on a point of law.

This system would have no effect on the major problem that most of those injured in medical accidents gain no compensation.[1,2] Most are not injured by negligence, and many of those who are never make a claim. Nor would the new system do anything to reduce the incidence of accidents: indeed, the possibility that more cases might be settled

without recourse to the courts might reduce the already limited deterrent effect of litigation. The capriciousness of the present system would not be reduced at all because the criteria for deciding who would be compensated would be exactly as now. The new system might do something to reduce costs and delay, but the effect is likely to be minimal: as the consultation document says, 95% of negligence cases are currently settled out of court, and the 5% that go to court are the difficult ones that are least likely to be settled by arbitration.

What we need is not cosmesis but a cost effective no fault system combined with a strategy for reducing medical accidents. Britain could have a system like the Swedish one for about £50m,[8] almost exactly the same as the amount paid out by the NHS for medical negligence in 1990.[6] And a Swedish style system would mean that many more people were compensated with far less of the money ending up in lawyers' pockets.

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NHS reforms: the first six months

Judgment suspended

Only those who believed their own prophecies of doom about the changes in the NHS will be surprised by the NHS Management Executive's report on the first six months of the experiment.[1] The NHS, quite predictably, went on much as before. The management executive's roll call of statistics provides a reassuring picture of a service that continued on much the same trajectory as in previous years, with an increase in the number of patients treated and a reduction in long waiting times. No doubt the report will be much invoked in the election campaign that has already begun. But what does it tell us about the success, or otherwise, of the government's strategy? And what are its wider implications for the debate about health care policy?

One conclusion can be drawn with some confidence. This is that the problems of transition—of introducing an extraordinarily complex set of changes—have been managed with remarkable success. In a sense, the report is a monument to the dedication and resilience of the NHS's staff. Instead of retreating into sullen resentment of the changes imposed on them they have clearly risen to the challenge of change. There does not seem to have been the sudden, catastrophic collapse in morale predicted by the opponents of the government's policies, which would surely have been reflected in the performance of the NHS as a whole.

But all that this indicates is that exaggeration tends to rebound on its authors. Apocalyptic prophecies are all too easily discredited when the end of the world (or of the NHS) does not arrive. The real question is how, over time, are we to evaluate the impact of the changes? The point can be simply illustrated. The management executive's report predicts that the number of inpatients treated will rise at a rate of 1·5% this year. This compares with an annual average increase of 2·0% between 1978 and 1988, which, however, fell to 1·2% in the last three years of the period.[2] So it would seem possible to present the post-change statistics as showing either a decline in the secular trend or an improvement on previous years. And the interpretative ambiguity would be compounded, of course, if account was taken of the problems entailed in generating accurate and comparable data over time and the relation between NHS outputs and the input of funding.

What, in any case, should be the currency of evaluation? The NHS's productivity is, clearly, only one dimension of performance, although the Audit Commission's recent report suggests that there is much scope still for improvement.[3] Another dimension is the NHS's capacity to reduce waiting lists and times: these are notoriously difficult to interpret,[4] and concentrating on them may have perverse effects. The changes were after all designed to have wide ranging effects, among them the promotion of greater responsiveness and choice as well as of higher standards and quality. Here, without agreed criteria for assessing progress, there is a danger that the NHS will fall victim to a battle of case studies or anecdotes.

So, for example, the management executive's report cites several success stories, such as the introduction of specified standards for appointments and the use of various devices for eliciting consumer opinions. It can also draw on the results of a survey of patients of trust hospitals,[5] which showed increased satisfaction. The critics of the NHS reforms, however, will no doubt be able to fire off a salvo of counter-anecdotes, with hospital trusts running into financial trouble and patients denied extracontractual referrals. What this sort of approach cannot tell us is whether such instances reveal general trends or are aberrant examples, whether they reflect problems of transition or indicate flaws inherent in the design of the post-1989 NHS.

There is a further difficulty in coming to any conclusion about the success or failure of the NHS reforms on the basis of the management executive's report. If the NHS weathered the first six months of the changes relatively successfully, as it undoubtedly did, does this indicate that all is set fair for the future or that it was exploiting and using up the capital of dedication built up over the previous 40 years? In short, short term effects cannot yield a judgment about the long term impact of the changes. This point applies with perhaps special force to some of the unanticipated effects of the reforms, notably the changing balance of power between general practitioners and hospital doctors: the full effects of this will clearly take time to work themselves through. The dangers of rushing into premature evaluation are just as great as those of knee jerk predictions of disaster.

One conclusion to be drawn from the management executive's report may, therefore, be that there is an urgent need to develop a long term strategy of evaluation. Rightly or wrongly, the executive's half term report has been widely seen, and contested, as a contribution to political debate—a reaction accentuated by the approach of a general election