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Steaming through the NHS

Time for the profession to unite

All ages have their fashions and in crime today's is "steaming": a gang runs amok through a crowded train or carnival demanding money at knifepoint. The aim is achieved through bewilderment and fear, much as in Clausewitz's description of total war.

The government has used a comparable strategy as one of the two prongs in imposing its plans for the fourth reorganisation of the health service. Announced initially by the Prime Minister on television, the inquiry's remit, conduct, and input remain undisclosed (as did the membership of the Cabinet committee). Thereafter communication has been sharp and in public: a series of synchronised and accurate leaks to the press beforehand; a razmattaz media launch; and an inordinately short timetable for the professions' responses.

These new proposals need to be seen in the political perspective. Having curbed the power of the industrial trades unions, the government is now tackling the power of the professions—schoolteachers, academics, and lawyers. In planning the reform of the last, for example, there was a similar lack of contributions by professionals: no solicitor, barrister, or judge was consulted. Moreover, once such plans have gone public the second prong of the government's attack is to deride any professional complaints; in the case of the NHS, we are told, these come from Luddites, a BMA that is out of touch with its members and that has opposed any projected change in the NHS in the past 40 years.

As was evidently intended, the proposals in *Working for Patients* are difficult to debate; to the shallowness of the original rhetoric has been added that of the working papers, which lack any detail. But some comment is possible. Already it is clear that the necessary skills, equipment, and experience for the envisaged information systems are not available; that few experiments have been done (and those that have are not complete); and that no pilot trials are proposed (as was suggested by Alain Enthoven, the guru of NHS reform by management). Doctors are convinced that the proposals are likely to lead to a two tier structure—in both hospitals and general practice. Add to this the ignoring of the vital aspects of research, training, and community care, and the politicisation of all levels from the Secretary of State downwards and it is not fanciful to talk about the end of the traditional health service, with its low administrative costs and its decent principle of uniform access to a high standard of medical care. And at a time when large scale privatisation is underway can that of the NHS be far behind, given that the proposed new structures, such as budget holding practices and independent hospitals, make it almost axiomatic that they behave like commercial enterprises.

Nobody should lose sight of why the whole exercise started: mounting concern at the funding crises in the acute sector, typified by cancelled operations, such as cardiac surgery on children. This led to protests by both the public and the profession, with the presidents of the three major royal colleges seeing the Prime Minister. None of this crisis will be diminished by the white paper's proposals. There is no more money—indeed, there will probably be less given the heavy expenditure on administration and information systems. All that has happened is to transfer responsibility for the health service's failings from the centre to the periphery, a device to shield the government from public anger and to divert attention from the salient fact: Britain spends proportionately far less on health than its civilised neighbours.

Clearly Mr Clarke has based his strategy on a study of history, aiming at avoiding the "mistakes" of his predecessors Aneurin Bevan, Kenneth Robinson, and Barbara Castle, who he sees as having given in to the unjustified and importunate demands of the doctors. (And if Bevan stuffed consultants' mouths with the gold of merit awards, Clarke seems intent on ingratiating the managers with the silver of opting out.) We should contrast the long drawn out planning of the health service—from 1936 to 1948—with expert advice and widespread consultation, with this administration's year of secret discussions and little consultation. Initially, it has to be said, Clarke has made the running. Public opinion polls suggest some disquiet but the picture is now so complex and confused that few outside the NHS appreciate just how far it will decline from its present level. Even the debate in the House of Lords showed a disappointing appreciation of the facts and how far rhetoric had triumphed over realism.

The profession, already portrayed by the government's propaganda machine as reactionary and stubborn, should also learn from history. It is little use, for instance, trying to counter a blitzkrieg with intellectual arguments—conceding that parts indeed of the white paper are excellent, objecting that some of them are already being introduced by the profession, and pointing to the disaster many years ago when an untried computer system was imposed on an unprepared London teaching hospital.

But doctors and nurses do have some ammunition. No health service can be run without the cooperation of all the health professions: a total refusal, for example, to implement

the proposals for general practice budget holding and hospital opting out would negate much of the enterprise. The public must be told repeatedly about the likely consequences of the proposals, and the BMA council has launched this exercise. And negotiation must take place—and on equal terms, with flexibility and without the duress of a short timetable which owes more to political expediency than to the issues at stake.

In the negotiations the BMA and the royal colleges must speak with one voice, for any seeming division will be exploited to the full. The proliferation of colleges and faculties since 1948 makes this even more difficult, and so far their voice has not been heard. But it is important that the colleges should find tough and skilled leaders of the calibre of Webb-Johnson and Moran; after all was it not Bevan who said that under their charters the royal colleges had the duty of advising the government of the day? The British public and the health professions deserve better than a return to the poor law; though normally both the BMA and the colleges and faculties have separate roles, on this occasion they must stand together.

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Editor, *BMJ*

Percutaneous balloon valve dilatation

Good for the pulmonary valve but less good for others

Percutaneous balloon dilatation has been used successfully in treating stenosis of the pulmonary, mitral, aortic, tricuspid, and prosthetic valves in both children and adults. Initial reports have described appreciable short term haemodynamic and symptomatic improvement and a low incidence of the complications of emboli and acute valvular regurgitation. Some stenotic valves are, however, far more amenable to balloon dilatation than others, and the United States Food and Drug Administration has approved only dilatation of the pulmonary valve. It is now considered to be the primary treatment for children and adults with pulmonary stenosis.

Balloon dilatation of the mitral valve was first performed successfully in 1984 by Inoue.[1] The procedure works by separating fused commissures and fracturing nodular calcium within the mitral leaflets. In 1985 Lock *et al* described their results in eight children and young adults with rheumatic mitral stenosis who underwent percutaneous balloon dilatation.[2] It almost doubled the mitral valve area, and catheterisation after two to eight weeks showed persistent haemodynamic improvement in seven of the eight patients.

These earliest cases were limited to young patients without mitral valve calcification or mitral regurgitation, but balloon dilatation has now been tried in elderly patients with severe calcified mitral valve disease.[3-5] Over almost three years our coworkers in this laboratory performed percutaneous balloon dilatation of the mitral valve in 87 patients: cardiac output increased by almost a quarter, mitral valve area was almost doubled, and the mean mitral pressure gradient was halved. Three patients had cardiac tamponade, one had papillary muscle rupture and a coronary embolus, two had a cerebrovascular accident, 21 had an atrial septal defect created, and one died. After a mean of 14 months' follow up 77 patients showed improvement in their symptoms, four had had recurrent symptoms, and eight had died. Palacios *et al* reported similar results in 172 patients with severe mitral stenosis.[5] Complications included death in 2% of patients, severe mitral regurgitation in 1%, thromboembolism in 2%, heart block in 1%, and pericardial tamponade in 1%. McKay *et al* achieved similar results with a double balloon technique in 12 patients with rheumatic mitral stenosis.[6] Mitral regurgitation did not increase in any patient, and there were no embolic episodes; small left to right shunts developed in two patients.

Based on these results and others[7] we advise balloon dilatation of the mitral valve for two groups of patients: those who are at high risk for an operation because of severe pulmonary hypertension, biventricular heart failure, and advanced age or associated medical conditions such as chronic pulmonary or renal failure and those who are not suitable for either long term treatment with anticoagulant drugs or a porcine bioprosthesis.

Percutaneous balloon dilatation of the aortic valve was first performed in 23 children and young adults by Lababidi *et al* in 1984 and subsequently by Rupprath and Neuhaus in 1985.[8,9] Successful balloon dilatation in adult patients with calcific aortic disease was first described by Cribier *et al* in 1986,[10,11] and several large series have been recently reported. Our coworkers have performed balloon dilatation of the aortic valve in 193 consecutive patients and have achieved a 50% increase in aortic valve area, a small increase in cardiac output, and a reduction of the peak aortic valve pressure gradient by half.[12] The early mortality of 3·5% is comparable in this elderly frail group to that from an operation. Three quarters of the patients were free of symptoms 7·5 months after the procedure. The mortality at six months was 18%; medical treatment results in a 43% mortality at one year.[13] Restenosis occurred in about four fifths of patients.

Letac and coworkers recently reported their results in 218 adult patients, over half of whom were aged 75 or older and a third of whom were 80 or older.[14] They produced a halving of the peak aortic gradient and almost a doubling of the aortic valve area. Follow up of 144 of their patients at a mean of eight months after dilatation showed that 24 had died and in 120 the symptoms had improved. Similar results were reported by Block and Palacios in 54 patients who underwent balloon dilatation of the aortic valve with the retrograde arterial technique and in 36 patients in whom the transseptal anterograde technique was used.[15] Eight patients died in hospital within one week after the procedure. All other patients showed an improvement in their symptoms, but at follow up an average of almost six months after dilatation 23 patients had died and 22 were classified as New York Heart Association functional class III and 22 as class IV. Repeat catheterisation was performed in 15 patients, 13 of whom had recurrent symptoms. The restenosis rate was predicted to be 56%. Sprigings and coworkers have recently reported their experience from Britain with percutaneous balloon dilatation of the aortic valve.[16] They showed a reduction in the peak aortic valve pressure gradient and an increase in the aortic valve area, but restenosis was the rule. Only half the patients survived for a year.

Balloon dilatation of the aortic valve thus achieves only a modest and temporary improvement in valve function, symptoms, and outcome in elderly patients with severe calcific aortic stenosis. This is presumably because the fracture through the calcium deposits within the valve cusps