In east Gwent a project was designed around this philosophy. The Bridges Community Centre was opened in 1987 in what had been a derelict factory canteen on a large industrial site in Monmouth. Joint funding by the Welsh Office and Gwent Health Authority provides a day hospital on two days a week and a day centre, run by volunteers, on three days a week. The project has about 90 clients overall. From the start the project incorporated a screening nurse, who has competent administrative help.

Like my colleagues in Newport, I have been dismayed by the checks for people over 75; it is not just the collection of medical facts but also the appreciation of the social and personal difficulties of elderly people. If we screen intelligently how do we satisfy their uncovered needs? The answer must be to have a community based resource that unites medical and social health professionals.

The project awaits community care funding with some trepidation. Its five year funding has finished, and the family health services authority and health authority are making encouraging supporting moves. I fear, however, that the project will become lost in the confusion and enormity of the changes in community care funding.

The family health services authority and health authority are working with social services at the end of January to explain community care funding, but will this have come in time to save this local initiative? Clearly, the community care fund will require the active participation of both social service departments and the family health services authority and health authority in these community ventures.

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**Consultant episodes**

**Editor,—**Allyson M Pollock and Azem Majeed's arguments in response to our editorial on consultant episodes could perhaps be summarised as “the internal market is intrinsically flawed and we should not do anything that would delay its demise.” That is a valid view, but we believe that the internal market is likely to exist for the foreseeable future and that we should try to make it work as well as possible.

When we wrote the editorial it was true that most, but not all, of the evidence of opportunism had been reported from the United States. This was inevitable as the American market based system has been in place longer than the British, but there is increasing evidence of it in Britain as well. Pollock and Majeed argue that this behaviour is detrimental to the patient as the motive is profit in the United States but survival in the internal market here. This argument is untenable as some of the most dramatic changes in behaviour by American hospitals occurred when the so-called prospective payment system was introduced, when only 10% of hospitals were private, for profit institutions, and there is considerable evidence that, especially for rural hospitals in those states, the threat of closures indeed was to survive. A somewhat more complex issue that has not received adequate attention in Britain is the meaning of the word “profit” in the context of trusts, and some of the ideas being discussed resemble the strategies that have caused the Internal Revenue Service to question the tax exempt status of some American not for profit hospitals.

The thesis underlying our editorial is that if purchasing authorities are to base their activities on meeting epidemiologically defined need they should use epidemiological principles. This means that they should use data that are based on people and defined events. We cannot see how the continued production of inaccurate information can enhance equity of health care.

AILEEN CLARKE

Department of Public Health and Policy, Health Services Research Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT


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**Junior doctors' hours**

**Editor,—**Ellis Field suggests that increasing the number of consultants to help reduce junior doctors' hours would alter the nature of senior posts for the worse and advocates a substantial increase in junior staff. While a corollary of the new deal may be that some consultants will have to take a more direct role in the acute management of patients, this in no way diminishes the attraction of a senior post. The thought of spending another year in training to achieve this goal does, Field describes the increase in the number of junior doctors as temporary but fails to offer any mechanism to phase out these posts in the absence of appreciate expansion in the number of consultants. Had we been as free from the fetters of manpower planning as Field when we negotiated the new deal the problem could have been solved overnight.

An increase in the number of seniors is only one option proposed by the signatories to the new deal, who included consultant representatives. Changes in the working patterns of juniors are necessary. In addition, consultant firms are no longer appropriate in many settings and a team based approach will often result in better care for patients and improved experience for juniors, who will be sufficiently awake to benefit from the "apprenticeship method of transmitting skills and knowledge..." that Field advocates. Where a rota system maintains the most appropriate form of out of hours cover a consultant may have to be directly on call to an experienced senior house officer. None of these could be regarded as solutions in themselves, but taken together, and in combination with other measures outlined in the new deal, they can make a substantial improvement.

The Department of Health must accept that without fundamental changes in the contract, the body and rationalisation of acute services the new deal will undoubtedly fail. If it does the alternative of a statutory limit on hours of work similar to that proposed by the European Commission would destroy any potential in manpower control just as surely as Field's proposals.

V RALLEY

Consultant, Junior Doctors' Committee, Belfast BT4 2EU

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**Umbilical cord clamping in horses**

**Editor,—**It is interesting that obstetricians have just realised what has been known to veterinary practitioners for many years.1 In equine practice it is mandatory for the stud groom to wait until the umbilical cord has independently pupiled before clamping it; this takes 30-60 seconds. If the cord breaks—for example, if the mare is standing when she delivers—then the foal is at risk of infection as well as anaemia, for as much blood as possible should be passed to the foal. Whenever I have conducted a human delivery I have always insisted that the cord is not clamped too soon, and I am interested that my belief has now been scientifically verified.

JUNE ALEXANDER

Swanland, Northumberland, England, NE71 4PE


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**Correction**

**Alternative allergy and the GMC**

Stephen Davies and Damien Downing (30 January, pp 328-9) mistakenly stated that Caroline Richmond handed over a draft report from the Royal College of Physicians to the high court. The court obtained this report by subpoena.

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1 BMJ, first published as 10.1136/bmj.306.6874.398.d on 6 February 1993. Downloaded from http://www.bmj.com/ on 1 September 2023 by guest. Protected by copyright.

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