Postcode prescribing is alive and well in Scotland

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Consultants’ new contract

Shurely shome mishtake?

Editor—I think that there must be a mistake and I have downloaded the wrong contract from the BMA’s website.1 The one I downloaded offers a 4% pay rise in return for a 16% increase in my clinical workload. Further pay rises are at the whim of my managers, to be paid five years in arrears provided that I meet conditions over which I have no control or work unpaid overtime.

The contract I downloaded is a licence to enable my managers to order me in for routine surgery and clinics on weekend evenings, Saturdays, and Sundays, for no extra pay, while paying me £1 an hour to be on call at other times. Could someone please send me the other contract that Peter Hawker and the BMA are hailing as a resounding victory for my colleagues and me2 while I vote no to what is clearly a different contract.

William Westlake consultant ophthalmologist
Truro TR1 3LX
willandsam@willandsam.fsnet.co.uk

1 Consultant contract framework. Available at: wvchma.org.uk/appx/Content/_Hub+cos+c+contract (accessed 3 July 2002).

So called victory in private practice obscures real contractual problems

Editor—Reports on the proposed consultant contract have focused too heavily on the concessions obtained over private practice and the headline figure of a 20% pay rise.3 The pitfalls of the contract far outweigh this victory.

Firstly, few doctors will immediately, or in the near future, get a 20% rise in pay. Essentially we are being promised a 20% rise staged over 20 years, or 1% a year. For many this rise will be offset in part by loss of domiciliary fees, category 2 work, and the loss of intensity payments. My own pay rise will be 2.5%—hardly a princely sum given I work full time for the NHS.

Secondly, the new contract seeks to make evening working up to 10 pm and weekend morning work an acceptable part of the working week, remunerable at standard rate. I find this appalling. Junior doctors have spent years fighting to be remunerated at above the standard rate for working unsociable hours. Should it be any different for consultants? And if the aim is to keep people in hospital medicine why pursue such family unfriendly initiatives?

Thirdly, too much control is being handed to managers—both in terms of when work is done and when salary increments are paid. The new salary introduces two forms of performance related pay: the revamped merit award scheme and the basic ciliary fees, category 2 work, and the loss of intensity payments. My own pay rise will be 2.5%—hardly a princely sum given I work full time for the NHS.

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ability of private practice, such practice is unlikely to be a significant cause of long waiting lists in the NHS.

Steve George reader in public health
John Primrose professor of surgery
University of Southampton School of Medicine, Southampton, SO16 6NH


Weak negotiators strike again

Entror—I left the NHS two years ago when the morale of consultants was, I thought, at an all time low. We had been rendered essentially powerless by hospital managers, who were paid a low salary for our expertise and clinical commitment, and were the victims of continual government spin depicting us as lazy, uncaring, unsafe Bentley-driving moneymongers with huge private practices. I was particularly frustrated that our representatives, the BMA, repeatedly failed to assert our real position and always seemed to climb down when challenged by negative spin. I can see now that nothing has changed.

This new contract is an appalling deal, and I am astounded that the BMA negotiators consider it a victory. If you offered the equivalent deal to any other professionals, such as barristers or dentists, they would laugh at you. Hospital porters would not accept the extension of the normal working day as proposed in the contract. Some consultants in the middle bracket will actually take a pay cut. The only significant pay rise is the £10 000 for newly appointed consultants, who, in reality, will earn less than the current salary level until 2006, and it will be 2008 before I recoup my lost earnings. My so called pay rise will begin in 2008-9, an average of 2% per year over the following five years (subject to managerial appraisal) and assuming that there are sufficient funds to afford it. This is the reality of the proposed new contract for me. It seems a long way from the headlines of 22 June.1

My vote will be a clear no to the negotiating team’s proposals. The proposed move to a 40 hour week significantly disadvantages all consultants who work on a less than full time basis. It would seem the negotiating team either forgot we exist or believe we are a low priority group compared with others.

I recommend all consultants who work part time, particularly those who have been in post around four or five years, or more, get out their calculators. You may well find that your negotiators have negotiated a pay cut for you.

Diana C Webster consultant
NHS Grampian, Summerfield House, Aberdeen AB15 2RE
diana.webster@ghb.grampian.scot.nhs.uk

1 Hargreaves S. Government makes U turn on private practice ban. BMJ 2002;324:1473. (22 June.)

The negotiating committee should come up with a new agreement

Entror—The framework agreement has removed our ability to work in a professional manner and organise activity for the benefit of our patients.1 The idea of the rigid session during which attendance in the hospital is mandatory means that no activity will be started in future if it might over-run the end of a session. In addition, there will be no stimulus to be efficient and get more done as an early end to the session is now not rewarded. Although this flexibility is abused by a small minority of doctors, the vast majority use it to organise work as efficiently as possible.

Am I to be paid for my meal breaks? If not, I will have to take them as a matter of right as I would be a complete fool if I worked over a lunchtime without being paid. The new contract rewards the clock watcher and treats the doctor who stays until the job is done as an idiot. The only staff left on a professional contract will be managers, and I am afraid I simply do not trust statements such as “we would never interpret the contract in that way.” If it is written down, it can be enforced.

I do not understand why, as a consultant of some 14 years, I will take me 23 years from appointment to reach the salary maximum, whereas a newly appointed consultant would take 19. I wrote to Douglas Bilton, acting secretary of the Central Consultants and Specialists Committee on this matter and was told that this was the best that could be done to bring the deal in under the financial limits imposed. I have no problem with new consultants being awarded a decent salary, but I object strongly to my colleagues and me being discriminated against. We are the group who did a large number of appalling rota changes and did not get the salary or time off given to current trainees. Why should we be penalised again? If the contract needs to be phased in, then an equitable scheme for all should be sought.

Although the idea of payment for emergency work and so on out of hours is laudable, sessions to cover onerous on-call commitments have always been negotiable locally. All that has happened so far is that this principle is to be formalised nationally, but with the loss of recognition of the nature of unsocial hours.

We can do much better, and for the good of the service we certainly ought to. The negotiating committee should take this framework back.

Crispin Best consultant paediatric anaesthetist
Royal Hospital for Sick Children, Glasgow G3 8SJ


Summary of responses

Entror—By 3 July 22 respondents had sent us 23 responses to the two news items on the consultants’ new contract.1 Sixteen respondents were scattered throughout England, from Truro to Newcastle; three wrote from Scotland, and one each from Belfast, Dublin, and Jersey. Four were consultants in various subspecialties of anaesthesia or psychiatry, two were consultant physicians, and two were consultants in accident and emergency medicine. The 10 other respondents were from a wide range of disciplines, including academia, radiology, endocrinology, and clinical neurophysiology.

Condemnation of the contract was unanimous.

Graeme Weiner, a consultant otoarynologist in Exeter, rushed to read the latest on the contract in the BMJ of 22 June but was incredulous to find there was none. He suggests the journal commission an article “by a couple of employment law specialists (and perhaps a human rights lawyer) so that we may see how truly awful the proposed framework is.”

Others criticised the use of spin in reporting the new contract. Lesley Wilson, consultant old age psychiatrist from Jersey, said that the BMJ’s headline was unfortunate and “will tend to support the widely held
Gold for the NHS

No natural limitation exists on demand for services free at point of supply

EDITOR—By far the most encouraging sentence in Robinson’s editorial is the last: “There is a strong case for arguing that UK healthcare policy should be driven by the supply side rather than the demand side reform.” Yet there is not a word of this from the chancellor or the secretary of state or in the report by Wanless, whose terms of reference guaranteed his conclusions. Even working within those limitations Wanless managed to generate some gratuitous divorce, saying that the cost of health care is likely to fall as we take greater measures to improve our health.

There may have been some excuse for Aneurin Bevan’s assessment of budgetary realities, but surely 54 years’ unvarying experience has been enough to convince us of the truth of another health secretary’s assessment (Enoch Powell’s): there is no natural limitation on the demand for any good or service free at the point of its supply. Until that is grasped and fully understood, those working in the NHS will continue to be the poorly paid providers of inferior care to an ungrateful public.

Brian Campbell consultant physician
Acute Medicine, Western General Hospital, Edinburgh EH4 2XU
Kelly.Black@lhft.scot.nhs.uk

What exactly is being bought with this gold?

EDITOR—Two concerns came to me when I read Robinson’s editorial about the plans for unprecedented rates of growth in NHS spending.

The first is, what exactly is the government buying with the extra billions it is planning to spend? Is it hoping to buy more medical treatment on behalf of the public? Is it hoping to make the population healthier by so doing? If it is the latter then the government has the power to make the right decisions to achieve its aims, whereas the government is relying on the National Institute for Clinical Excellence (NICE), the Scottish Medicines Consortium, the Postcode prescribing is alive and well in Scotland

EDITOR—We had understood that one of the intentions of the National Institute for Clinical Excellence (NICE) was to rationalise the introduction of new drugs and technologies across the United Kingdom so that NHS patients would have equitable access. This has plainly not happened. We illustrate the problem with three recently licensed drugs, imatinib, irinotecan, and trastuzumab.

Imatinib has yet to be appraised by the National Institute for Clinical Excellence, but our local haematologists completed the paperwork for approval by Lothian Health Board’s drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.

Irinotecan was approved by the National Institute for Clinical Excellence and then by the Health Technology Board for Scotland. However, the drug evaluation panel for Lothian Health Board’s drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.

Trastuzumab was approved by the National Institute for Clinical Excellence and then by the Health Technology Board for Scotland. However, the drug evaluation panel for Lothian Health Board’s drug evaluation panel. The drug was not approved. Shortly afterwards the Scottish Medicines Consortium issued guidance to indicate that it should be made available: we await the result of an appeal to the drug evaluation panel. Meanwhile patients in Fife can get it.

We must start to examine the sources of demand for health care and learn to modify them early. This will require courageous medicine and courageous politics.

Peter Davies general practitioner
M집den Stones Surgery, Halifax HN2 8RQ
npdgavies@doctors.net.uk

1 Robinson R. Gold for the NHS. BMJ 2002;324:987-8. (27 April)
2 Moore W. NHS to receive an extra £40bn over next five years. BMJ 2002;324:955. (27 April)
sion in favour of a new drug should result in automatic top-slicing funding going direct to the departments dispensing the drugs, so that clinicians do not have to apply locally for approval and funding.

The alternative is a return to the old system of postcode prescribing. This, however, would require politicians to acknowledge that local health boards have the right to set different priorities and are prepared to take the clinical consequences of their decisions.

David Cameron  
senior lecturer in medical oncology  
University of Edinburgh and Edinburgh Breast Unit, Western General Hospital, Edinburgh EH4 2XU

Michael Dixon  
consultant breast surgeon  
Edinburgh Breast Unit, Western General Hospital, Edinburgh EH4 2XU

vCJD: the epidemic that never was

New variant Creutzfeldt-Jakob disease: the critique that never was

Editor—Venter’s article on new variant Creutzfeldt-Jakob disease (vCJD) is intended to stimulate debate, which we hope will be better informed than the article itself.1

Is variant Creutzfeldt-Jakob disease a new disease? Venter places great emphasis on Creutzfeldt’s case, but this patient did not have Creutzfeldt-Jakob disease. The illness was characterised by gait disturbance, a relapsing and remitting course, nystagmus, and status epilepticus. These are not the clinical features of variant Creutzfeldt-Jakob disease and, crucially, the neuropathological appearances were “not characteristic of Creutzfeldt-Jakob disease.”

In 1996 confidence in the novelty of variant Creutzfeldt-Jakob disease was based largely on the identification of a neuro-pathological phenotype that was distinct from that experienced in the United Kingdom from 1970. Since then archival issues have been reviewed in many countries and no past cases with a similar neuropathological pattern have been found.2 Retrospective epidemiological surveys in England and Wales have not identified any missed cases of variant Creutzfeldt-Jakob disease from 1979-96.3 Current evidence strongly supports the hypothesis that variant Creutzfeldt-Jakob disease is indeed a new disease.

Was variant Creutzfeldt-Jakob disease identified solely because of improved surveillance? There was a doubling in the annual death rates for sporadic Creutzfeldt-Jakob disease in the United Kingdom between the 1980s and the 1990s, but similar increases in the apparent death rates for sporadic Creutzfeldt-Jakob disease had occurred in other European countries.4 These countries, including New Zealand,5 have been subject to similar potential improvements in case identification, but variant Creutzfeldt-Jakob disease remains a disease occurring predominantly in the United Kingdom, despite significant numbers of young suspect cases being investigated in each country (figure). Venter argues correctly that the curve for the epidemic of variant Creutzfeldt-Jakob disease does not parallel the number of cattle with bovine spongiform encephalopathy (BSE) between 1983 and 1988. However, human exposure to the BSE agent almost certainly extended to 1996 and depended on a range of variables not addressed by his model. These include the species barrier between cattle and humans, the numbers of cattle in the final year of the incubation period, the load of bovine central nervous tissue entering the human food chain, the efficiency of legislative measures, and temporal changes in food production. Extrapolation from conventional foodborne epidemics to epidemics of variant Creutzfeldt-Jakob disease and BSE is clearly too simplistic.

A wealth of laboratory evidence supports the hypothesis that the BSE agent is the cause of variant Creutzfeldt-Jakob disease. Venter states correctly that there is no direct evidence that the BSE prion is infectious to humans, but obtaining such evidence would be difficult to justify ethically as this would involve inoculating humans with the agent. A judgment on the link between BSE and variant Creutzfeldt-Jakob disease inevitably depends on an assessment of a range of clinical, pathological, epidemiological and laboratory based evidence. There is now overwhelming evidence that BSE is the cause of variant Creutzfeldt-Jakob disease, although there remain uncertainties about the future number of cases and the mechanism of transmission of BSE to humans.

R G Will  
consultant neurologist  
R S G Knight  
consultant neurologist  
H J T Ward  
consultant epidemiologist  
J W Ironside  
director  
National Creutzfeldt-Jakob Disease Surveillance Unit, Western General Hospital, Edinburgh EH4 2XU

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consultant breast surgeon  
Edinburgh Breast Unit, Western General Hospital, Edinburgh EH4 2XU

1 Venter GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:856-61.

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Letters

New variant Creutzfeldt-Jakob disease: the critique that never was

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consultant neurologist  
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J W Ironside  
director  
National Creutzfeldt-Jakob Disease Surveillance Unit, Western General Hospital, Edinburgh EH4 2XU

1 Venter GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:856-61.
patients certainly did not have new variant Creutzfeldt-Jakob disease. Perhaps we should drop the "C" from Creutzfeldt-Jakob disease.

Markus Reuber  
specialist registrar  
Department of Neurology, Leeds Teaching Hospital  
NHS Trust, Leeds, LS9 7TF  
nreuber@doctors.org.uk

1 Venetis GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.
4 Richardson EE, Masters CL. The neurology of Creutzfeldt-Jakob Disease and conditions related to the accumulation of PrP(Sc) in the nervous system. Brain Pathol 1995;5:33-41.

Possibility of BSE being cause of variant CJD is indeed biologically plausible

Editor—Venters argued against bovine spongiform encephalopathy (BSE) causing variant Creutzfeldt-Jakob disease. In fact, the biological plausibility of this being the cause, the strength of the epidemiological association, and the experiments indicating that the same prion is involved are all good. Incubation periods for BSE are proportional to the life expectancy of the animal affected. The disease’s incubation period is 18% of a cow’s life expectancy and would be expected to about double when crossing to another species—that is, to 50% of 70 years in humans. Thus the incidence of a disease due to BSE in humans would be predicted to peak in 2014. A few human cases would be seen before 2000 and none early in the 1990s. Small outbreaks would be expected early in the epidemic before they become lost among a high background prevalence. The pattern of variant Creutzfeldt-Jakob disease cases fits this.

Everyone in the United Kingdom has eaten on average over 50 meals of the tissues of cattle infected with BSE; this figure would be lower in other countries. The novelty of variant Creutzfeldt-Jakob disease is not now questioned as it is different from kuru on histopathological grounds and scrapie prion (PrPsc) biochemistry. No similar cases before 1995 have been found.

BSE infects a different range of animals from scrapie and infected all the species inoculated experimentally except chickens. When fed BSE, 25% of sheep, 33% of goats, 50% of kudu, 100% of mice, and 100% of mink died. Calculating this percentage for humans is difficult as it is early in the epidemic.

BSE prion doses to which humans may have been exposed might well cause large numbers to become infected despite the inefficiency of the oral route. Beef exported from the United Kingdom to France was mainly older animals, specific tissues, and calves. This means that there was a relatively high dose of prions per meal in France, and this fits the number of cases of variant Creutzfeldt-Jakob disease seen there. Why younger people are apparently becoming infected is not clear, but this does not mean that BSE is not the cause.

Identical pathology and PrPsc glycoforms are produced in mice when variant Creutzfeldt-Jakob disease, BSE, or spongiform encephalopathy (PrPC) is inoculated. This is exceptional evidence that the same prion is the cause. PrPsc associated with BSE will alter human normal prion protein to the abnormal form in vitro, but it is not surprising that transgenic mice expressing human prion protein did not become infected easily with BSE.

Steve Dealler  
consultant in medical microbiology  
Bury St Edmunds General Hospital, Bury St Edmunds, Suffolk  
steve.dealler@airtime.co.uk

1 Venetis GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.
2 Dealler SF. Should young UK cattle be considered free of BSE or is it endemic? Br vet J 2000;156:284-90.

Author has overlooked several findings that support his argument

Editor—Venters’s reappraisal of variant Creutzfeldt-Jakob disease (vCJD) is important because, even if new cases of the disease continue to be reported sporadically or in an occasional cluster, there is no evidence of an epidemic anywhere. But in dismissing the misfolded prion glycoprotein that “causes” bovine spongiform encephalopathy (BSE) as the cause of variant Creutzfeldt-Jakob disease in humans Venters overlooks other findings that support his argument.

Firstly, BSE began in dairy herds in 1986, almost immediately after the Ministry of Agriculture, Fisheries and Food removed controls on foodstuffs for cattle and mandated supplementary feeding with proteinaceous offal, often containing scrapie material, to increase milk production. This is a major epidemiological risk factor for the appearance of variant Creutzfeldt-Jakob disease.

Secondly, suckler-fed, grass-fed pedigree herds were virtually unaffected unless they were in contact with dairy cattle. Thirdly, BSE subsided when supplementary feeding with proteinaceous offal was banned.

Fourthly, ascertainment of unprecedented intensity has shown an excess of all five forms of Creutzfeldt-Jakob disease in the United Kingdom since 1989 but no excess of variant Creutzfeldt-Jakob disease in those at high, continuous, and percutaneous risk of occupational exposure to actual BSE—namely, veterinarians, and people working on farms and in cattle markets, abattoirs, butchers’ shops, and abattoirs.

Fifthly, the same ascertainment has identified variant Creutzfeldt-Jakob disease in younger people with questionable levels of presumed exposure from ingestion of cooked beef or beef products possibly containing BSE prion. An increase in incidence, from 0.8 confirmed cases per million in 1995 to 1.2 in 2000, is continuing, along with an overall increase in total (including iatrogenic) referrals but a decrease in all other forms of Creutzfeldt-Jakob disease.

1 Venters GA. New variant Creutzfeld-Jakob disease: the epidemic that never was. BMJ 2001;323:588-61.
3 Stewart GT. Witness statement to the BSE enquiry. 2000.
timely intervention is the key

Ennour—Johanson et al imply that medicalisation of childbirth has led to a high caesarean section rate and quote data from Catalonia to Ontario. They have forgotten their neighbours in the Republic of Ireland, where active management of labour is practised in some units. The National Maternity Hospital in Dublin, for instance, boasts a section rate that has been consistently among the lowest in developed nations.

Strict criteria for the diagnosis of labour, early amniotomies, use of oxytocin, and the involvement of a senior obstetrician at an early stage are cornerstones of the active management of labour. In addition, units in Dublin believe strongly in patient choice, and epidural analgesia is widely used. Do Johanson et al not consider these interventions to be medicalisation?

Active management of labour was designed primarily to reduce morbidity (and mortality) associated with prolonged labour—something that most obstetricians of the present generation seem to have forgotten about. One of the side effects of the active management of labour is a reduction in the caesarean section rate.

Surely the authors must accept that some of the reasons why the United Kingdom has a high section rate has to do with the fact that we don't know how to diagnose labour (ask any midwife or obstetrician and you will get a myriad of responses) and we don't know when to perform an amniotomy, use oxytocin, or involve a senior obstetrician.

No, the problem isn't that the medicalisation of childbirth has gone too far; rather, it's that we don't know when to intervene. We agree with the authors that visits to other units and countries should be encouraged. More of us should travel across the Irish Sea.

Johanson et al state that “Childbirth without fear should become a reality for women, midwives, and obstetricians.” As one of the cardinal fears of labour is pain, the widespread availability and use of regional analgesia should go a long way towards reducing this fear.

William Camann director of obstetric anesthesia Brigham and Women's Hospital, Harvard Medical School, Boston, MA 02115, USA wcamann@partners.org

Pregnant women at term with rupture of membranes before labour are subjected to routine induction of labour. Again, the paternalistic approach offers no choice. Expectant management for even the next 12-24 hours is perceived as too risky an alternative. Even pregnant women at 36 weeks' gestation are subjected to the same routine protocol.

All women in labour undergo routine midline episiotomy. Every woman is subjected to this regardless of gestation (term or preterm). The episiotomy rate approaches 100%.

The above practices are so entrenched that any change of practice would meet much resistance. Increasing medicalisation has led not to diminishing but to increasing numbers of medicolegal cases. A vicious cycle ensues. Obstetricians now act and intervene even more for fear of litigation.

Government health statistics show that the number of registered midwives declined in the past decade, from 1891 in 1990 to a mere 538 in 2000. During the same period the number of registered doctors rose from 19,921 in 1990 to 29,585 in 2000. This is for a population of 20 million in 1990 and 22 million in 2000.2

As Taiwan now seeks observer status in the World Health Organization, professional bodies and governments in Taiwan should promote obstetric practice as contained in the WHO report Care in Normal Birth: A Practical Guide, which aims at improving obstetric practice in normal childbirth.3

Peter S Yeh senior resident in obstetrics and gynaecology Taiwan Adventist Hospital, Taipei 105, Taiwan yehpeter@hotmail.com

Evolving general practice consultation in Britain

Increasing consultation time may not be straightforward

Ennour—Freeman et al plead for longer consultations in British general practice. A pilot study performed with six general practitioners in Glasgow shows that breaking the habit of short consultations may be difficult and longer consultations may lead to higher health service costs.

Our study piloted a randomised controlled trial of the effect of an increased booking interval on identification of the patient's psychological distress.7 Each doctor's surgery was randomised to either 10 minutes per patient (the normal booking interval) or 15 minutes. One of us (MS) offered locum sessions to make up the shortfall in available consultations. We recorded 65 consultations at each booking interval for each practitioner. After the consultation, patients


completed the general health questionnaire—12; doctors estimated psychological distress using a six point scale and recorded important outcomes of the consultations. Consultations were timed by a research assistant.

Data were collected from 781 consultations. When booking interval was increased by 50% consultation length increased by 12% from 5.9 minutes to 9.7 minutes. Longer booking intervals significantly increased the number of consultations in which the doctor arranged investigations (19.4% v 27.9%; P = 0.0069) and follow up appointments (43.8% v 53.7%; P = 0.0072). There was no significant effect on the proportion of consultations in which prescriptions were issued (51.0% v 54.7%; P = 0.34), physical examination carried out (66.8% v 66.8%; P = 0.96), or referral made (14.0% v 10.7%; P = 0.20).

There were no significant differences in identification of psychological distress between long or normal booking intervals (66.8% v 66.8%; P = 0.96), or referral made (14.0% v 10.7%; P = 0.20).

Longer consultations might necessitate redeployment of pharmacists

Editor—Freeman et al open an overdue debate about the length of consultation times. They address the question of why consultation times should be longer but do not consider how this might be achieved.

The workload in primary care is increasing faster than the workforce is. This is fuelled partly by demography, partly by increased health expectations, and partly by developments in treatment. The unremitting commercial gameplaying of the pharmaceutical industry, highlighted in an article in the same issue of the BMJ as Freeman et al’s article, adds another turn to this screw.

General practitioners are fully occupied. There is no prospect of a huge increase in the general practitioner workforce in the next decade. The only way for doctors to have more time is therefore for them to stop doing things.

There are a few activities that general practitioners might simply stop doing. Some may need legislative change, such as a move from repeat prescribing to repeat dispensing. This would probably save the average general practitioner about an hour a day. Other changes might need us to question some of our routine behaviours perpetuated by the convoluted fee structure of general medical services. Why do we need to see patients taking contraceptives twice a year? Why do we still dabble in antenatal care when midwives do it so much better? What is a “full postnatal examination” for?

The most effective way of freeing up time is to delegate. Get someone else to do it—preferably someone who is better at it than you are. The extended roles of practice nurses and nurse practitioners are a move in this direction, but there are so many calls on nurses that we are probably close to the limit of available staff. The largest untapped source of underused skill, however, is community pharmacists: the fact that so many are trapped behind their counters selling baby food and offering cold remedies of questionable efficacy is a waste of their clinical skills.

The future of the traditional high street pharmacy is threatened by the pincer movement of industrialised warehouse dispensing and the supermarket pharmacy. At present supermarket pharmacies are contributing to a manpower shortage, but warehouse dispensing could reverse this trend. The potential exists to redeploy pharmacists into general practices to review patients and supervise drugs, making best use of their knowledge and developing skills. This would free up general practitioners and enable them to extend consultations and improve the depth and breadth of care.

Arnold G Zernirmsky
London

Drummond MF. When is it cost-effective to change the medication: review by a pharmacist of elderly patients receiving repeat prescriptions in general practice BMJ 2001;323:1540.

Mark JM, Freeman et al. When is it cost-effective to change the behaviour of health professionals? JAMA 2001;286: 2988-92.

The lot of airline pilots and consultants is not so different

Entorr—A day in the life of a hospital consultant: is it so different from that of an airline pilot?—Awake from a restless night. Study the latest directive from the flying crew. Finish off writing lecture notes on emergency landing procedures. Set off to airport via a charity coffee morning to receive cheque to buy a new pilot seat.

Arrive Stansted. Pilots’ car park full of ground crews’ cars, so have to park some way away and walk to check-in.

Take morning flight to Paris. Mid-channel find out that there is only one trained air steward in the cabin and the rest are steward assistants; go back to help. Standing room only because of 30 overbookings.

Land; sprint across tarmac and take 9 am flight to Copenhagen. During flight two appraisals of navigators, answer 10 written complaints about cuisine, and lecture flight staff about latest safety procedures.

Land at Copenhagen. Race across tarmac and take 11.15 am flight to Brussels. Land 1 pm on two sets of wheels as one set now 15 years old (application to lottery fund for new set failed). Receive round of applause for good landing and a visit from a passenger whose duty free goods fell on his head.

Take flight to Athens. Co-pilot is new style trainee with 10 minutes’ flying experience. During flight talk down two other landings because staff are inexperienced.

Arrive Athens 3 pm. Immediate turn-round. Flight back to London Stansted 7 pm. Find car wheel clamped. No problem as bleep went off and I had to take emergency cargo flight to Glasgow. Big bonus: I was able to wave goodnight to the children as I flew over the house. Arrive Glasgow in the early hours of the morning; canteen shut so grab stale sandwich from vending machine and try to grab an hour’s sleep in airport terminal chair.

Still, it was better than yesterday.

Colin Trask
consultant in radiotherapy and oncology
Southend Hospital, Southend SS0 0RY

colin.trask@southend.nhs.uk

1. McDonald E. One pilot son, one medical son. BMJ 2002;324:1105. (4 May)