letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk.

The consultation in art: Henry Tonks

Editor – In his interesting *Consultation in art*, Professor Alan Emery cites Henry Tonks (1862-1937) as a renowned artist who had initially studied medicine (*Clin Med* January/February 2002, p74). Some further details of Tonks's first career may be of interest, as the medical education he received together with his early experience as a surgeon gave him special insights and opportunities as a an artist in the First World War, and formed an important background to his development as one of the leading figures in 20th century English art.

Henry Tonks was a student at the London Hospital Medical College from 1881 to 1886; after he qualified he was house surgeon to Mr Frederick Treves (later Sir Frederick Treves). Treves promoted his career as a surgeon (Tonks became FRCS in 1888), but increasingly he came to appreciate the extent of Tonks's talents as an artist and at the same time wondered whether he was temperamentally suited to a life-long career in surgery. Tonks himself had great difficulty in making up his mind between art and surgery, particularly as members of his family were strongly opposed to the suggestion that he might abandon the prospect of an assured future as a surgeon. Treves interceded on his behalf and persuaded them that his true destiny lay in art.

During the time that Tonks was house surgeon to Treves, he drew a design for the cover of the *London Hospital Gazette*. Forty years later the block containing Tonks's design was so worn that it could no longer be used. Tonks who was then Professor of Fine Arts at the Slade was asked if he would prepare another version. Tonks was apparently no longer proud of his juvenile work and suggested that Rex Whistler, aged 23 and one of his favourite pupils, be asked to undertake a new design. Thus, for well over a century, front covers of all the issues of the *London Hospital Gazette*, were adorned with designs made by two remarkably talented and distinguished artists.

I am grateful to Mr Jonathan Evans, archivist and curator, for providing information from the records of the Royal London Hospital.

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Retired Physician
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Dying with dignity

Editor – Dr McGoran's perceptive article strikes a chord (*Clin Med* January/ February 2002, pp43–4). It should be compulsory reading for all who complain of ageism in the NHS. Her final indignity would have been the inevitable referral to the coroner.

IAN MUNGALL
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Consultant nurses

Editor – Have I spotted an error in your recent editorial on consultant nurses? You assert that "some of the first specialist nurses, in diabetes, began work…during the 1950s…" (*Clin Med* January/ February 2002, pp5–6), but specialist tuberculosis nurses predated these by about 50 years[1,2]. No wonder tuberculosis is called the forgotten plague[3] – even our editor overlooks it!

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2 Robbins JM. Class struggles in the tuberculosis world: nurses, patients and physicians 1903–1915. *Bull Hist Med* 1997;71:412–34.
3 Ryan F. *The forgotten plague*. New York: Little Brown, 1992.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

NHS Direct: growing awareness and use

NHS Direct is a government-sponsored, nurse-led, 24 hour telephone information helpline available throughout the United Kingdom[1]. A study of consecutive new referrals seen in general neurology outpatient clinics at two district general hospitals in north-west England between January and March 2001 found that only 2% had used NHS Direct, only one for a problem related to the referral[2]. One possible explanation for this low figure may have been lack of awareness of the service. In a survey from an inner city general practice in Teesside in early 2001, only 8% of patients questioned directly, and 25% responding to a questionnaire, had heard of NHS Direct[3]. More recently, an investigation by the National Audit Office reported 3.5 million calls to NHS Direct in the year 2000–01 and predicted a doubling of call numbers in 2001–02[4].

Two further surveys have been performed, one in a cognitive function clinic based at a regional neurosciences centre in north-west England, and one in general neurology clinics at the same district general hospitals as a previous study[2]. These show increased awareness and use of NHS Direct (see Table 1). However, calls seldom related to the reason for referral. On only one occasion did a patient volunteer information about a call.

Although these study populations have the biases inherent in all hospital clinic-based surveys, nonetheless these figures corroborate the expectations of the

Table 1.

Outpatient Clinic	General Neurology (Jan–March 2001)[2]	Cognitive Function (Oct 2001–Dec 2001)	General Neurology (Jan–March 2002)
n	198	58 (new 39; FU 19)	211
Heard of NHS Direct?	–	34/56 (= 61%)	120 (= 57%)
Used NHS Direct?	4 (= 2%)	3/34 (= 9%: 5% of all consultations)	26 (= 22%; 12% of all consultations)
Call related to referral?	1/4	2/3	4/26

National Audit Office of increased use of NHS Direct[4]. Since most callers report themselves satisfied with information received[4,5], it seems reasonable to infer that calls help to shape patients' health beliefs and expectations, whether appropriately or not. Awareness of calls to NHS Direct may allow clinicians to focus on issues of particular concern to patients, and hopefully thereby improve patient satisfaction with their consultation.

References

1 Donaldson L. Telephone access to health care: the role of NHS Direct. *J Roy Coll Physicians Lond* 2000;**34**:33–35.
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4 The Comptroller and Auditor General. *NHS Direct in England*. London: Stationery Office, 2002.
5 O'Cathain A, Munro JF, Nicholl JP, Knowles E. How helpful is NHS Direct? Postal survey of callers. *Br Med J* 2000; **320**: 1035.

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Troponin I as a risk stratification tool in the district general hospital

The value of cardiac troponin measurement as a risk stratification tool in patients with suspected acute coronary syndromes and without electrocardiographic ST-segment elevation has been well established[1]. Recent guidelines advise troponin estimation in all patients with suspected acute coronary syndromes[2,3]. Early invasive treatment (coronary angiography and revascularisation where appropriate) is recommended in troponin positive patients while troponin negative patients can be discharged early with stress testing (before or after discharge)[3]. Utilising troponin in guiding treatment may have important implications with regard to bed resources, particularly in the district general hospital. We performed a retrospective audit to determine the effect of using troponin I on length of hospital stay in patients admitted with chest pain.

Our hospital, a district general hospital with on-site diagnostic coronary angiography, incorporated troponin I measurement into chest pain management guidelines two years ago. It was suggested that troponin I be measured on admission and 12 hours later in patients presenting with chest pain but without ST-segment elevation. The cut-off level for a normal troponin I (*Abbot* Axsym system) was <0.3 mcg/l, the lower limit of detection. The new guidelines suggested that i) troponin negative patients could be discharged earlier (with stress testing as appropriate) ii) troponin positive patients should be referred to the cardiologists for possible inpatient coronary angiography. Median length of hospital stay and clinical characteristics were determined by case note review in a random selection of 229 patients admitted with chest pain during a 6-month period prior to the introduction of troponin measurement. A similar audit was performed in 210 randomly selected patients admitted during a 6-month period after introduction of troponin measurement. Results from both patient groups were compared using the Chi 2 test. Our results demonstrated a shortening in median length of stay (from 3 to 2 days) in patients with non-diagnostic ECGs and cardiac risk factors/prior history of coronary disease. Extrapolated to all chest pain admissions, shows that this shortening would gain 1,351 bed days per annum (3.7 beds/day). However, this gain was offset by an increase in median length of stay (from 5 to 8 days) for high-risk patients presenting with ischaemic ECG changes. Extrapolation showed that this increase would yield a loss of 1,513 bed days per annum. Troponin positive patients were more likely to undergo in-patient coronary angiography (62% v 35%, $P<0.05$) and revascularisation (36% v 11%, $P<0.05$).

In conclusion, our audit shows that using troponin measurement in guiding treatment has important bed resource implications. Adopting troponin measurement reduces length of hospital stay in low-risk patients. However, using troponin status to help identify high-risk patients who require inpatient coronary angiography revascularisation significantly lengthens hospital stay. In hospitals without on-site diagnostic angiography, hospital stay may be further prolonged. We suggest that prompt transfer of high-risk (troponin positive) patients to tertiary cardiac centres will result in net bed-stay savings for district general hospitals.

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Patterns of childbearing amongst female hospital doctors and GPs

The article *Women in hospital medicine* by E Paice (*Clin Med* Sept/Oct 2001 pp344–5) highlights some important issues faced by