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.

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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

women working in the NHS and trying to achieve a reasonable balance between work as a doctor and family life. The problems faced by female doctors pursuing their career whilst trying to raise a family are becoming more apparent as more and more women enter and graduate from medical school. One of the greatest sources of stress for female doctors is the conflict between their career and personal life[1]. We undertook a questionnaire-based study involving female GPs' and female hospital doctors' experiences and views of child-bearing whilst working as a doctor. Our aim was to investigate the perception that by entering general practice, it may be easier for a woman to combine a career with having children than if she chose hospital medicine.

We found that female GPs were significantly more likely to have children than female hospital doctors. Problems amongst both hospital doctors and GPs related to their everyday difficulties. For example, hospital doctors frequently mentioned problems of obtaining good quality child-care, particularly during unsociable hours. Issues highlighted by GPs were care for their children during the school holidays, and a strong feeling that they were unable to spend enough time with their children because of the demands of their job. Our study reflects the report from the Federation of the Royal Colleges of Physicians[2] with a timely call for action. We have highlighted the urgent need for improvements in the working situation of female doctors both within general practice and in hospital. Recommendations for the future include a greater availability of part time work and easier access to childcare facilities.

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