book review

The National Health Service: a political history (2nd edition)

By Charles Webster. Oxford University Press, 2002. 284pp. £12.99.

There are several reasons why a new (2nd) edition of Dr Charles Webster's *Political history of the NHS* is timely and welcome. The most general reason is best given in his own words: 'as politicians embark on yet further major policy reviews, they appreciate more than ever before that the past record is crucial to the resolution of the crisis that they confront.' (I hope that is true; if not, it should be). A further important reason is that the first edition was completed soon after Labour came to office in 1997, too soon to allow any assessment of their impact. The new edition can now take a noticeably cool look at what has so far been achieved.

The first two chapters, which describe the origins of the NHS, and take the story up to 1979, remain the same – Dr Webster is too good an historian to revise for revision's sake. The few pages in the first edition at the end of chapter three (Continuous Revolution) which briefly commented on the new administration, have been rewritten as part of the new chapter, The Age of Labour, which records the achievement so far of New Labour. Much has been promised, less has been fulfilled; but the commitment of the government to the success of the NHS is beyond question – something that was less clear in a previous administration, which had immortal longings for an insurance-based system. The entirety of this edition will bring up to date the value of the book as a work of reference; and the interim judgment on the present activities adds a new and particular interest.

My love of oddities led me to page 220, where the Health Education Authority is said to be 'Thatcher-inspired'. That is formally true, but the 'inspiration' consisted in converting the 'independent' Health Education Council into a statutory (and possibly controllable) authority. The Council had been fishing in distasteful waters (inequalities, in health, no less) – a press conference was cancelled and the Council's Director, Dr David Player, dismissed.

'Conclusions' has also been rewritten, and there is an interesting variation. In the first edition, a standing commission to oversee the NHS was recommended, free of political influence. In itself, an excellent idea; but in the interval we have seen a plethora of controlling bodies, and observed the limits on independence. Coincidentally or not, the new section recommends instead a return to the basic NHS principles of public service. Again, the conclusion should be given in Webster's own words: 'It is doubtful whether any other basis of policy is capable of recapturing the "sense of excitement and enthusiasm" that the Prime Minister regards as fundamental for the revival of the NHS in the new millennium.'

SIR DOUGLAS BLACK
Telford

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 uses of troponins as a risk stratification tool

Editor – The letter by Sidhu *et al* (*Clin Med JRCPL* May/June 2002, p276) raises fundamental questions about the uses of troponins as a risk stratification tool in patients with suspected acute coronary syndrome (ACS). A normal troponin increases confidence in identifying patients at low risk; a raised troponin has sharpened awareness that many more patients warrant urgent invasive investigation and intervention. The problem lies in the availability of and access to such invasive management. At our hospital all patients admitted with chest pain possibly of cardiac origin have troponin T measured at 8 to 12 hours after the onset of pain.

Patients without ST elevation or left bundle branch block on their ECG but a raised troponin (greater than 0.1 mcg/l) are categorized as having a 'non ST elevation MI'. They are kept in hospital for five days and treated with subcutaneous enoxaparin. The nearest centre for invasive cardiology is twenty miles away and most of these patients are discharged home after five days with plans for out-patient treadmill testing. However, if necessary inpatient treadmill testing and angiography can be arranged.

The statement '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' is something we would support in principle but unfortunately does not happen. It would require a large expansion of cardiology services, including facilities for invasive cardiology. Till then one is better off having one's acute coronary syndrome in a teaching centre with improved facilities.

NIRMALAN ARULANANTHAM
Specialist Registrar

ALASTAIR MILLER
Consultant Physician

Department of Infectious Diseases and General Medicine, Worcestershire Royal Hospital

The changing face of acute medicine

Editor – The recent papers presented in Clinical Medicine identified the rapid change in the care of the acutely unwell patient, which has come about as a result of changes in the approach to acute medicine