

# book review

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## 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

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# letters

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## 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

(*Clin Med JRCPL*, July/August 2002, pp287–9). There is an increasing 'diagnostic compression' in the early stages after presentation, especially with respect to 'rule-out' strategies such as chest pain observation units<sup>1</sup>. In addition, length of stay and duration of treatment are becoming shorter for many conditions, especially toxicology. These factors result in many patients potentially being processed within 12 hours. The economics of observational medicine, in terms of direct costs, and risk-management savings, suggest that trusts stand to gain a definite advantage from implementing observation-unit medicine<sup>2</sup>.

As a result, the barriers between emergency medicine and acute medicine are becoming increasingly blurred. In the light of the Department of Health document *Reforming emergency care*, those managing medical urgencies surely need to investigate novel system modifications to find solutions to the difficulties of increasing supply/demand disparity and increasing emphasis on delivery of quality acute care.

#### References

- 1 Kelly A. Chest pain observation units. *Emerg Med J*. 2001;8(2):148.
- 2 Roberts R, Graff IV LG. Economic issues in observation unit medicine. *Emergency Medicine Clinics of North America* 2001;19(1):19–35.

SIMON SMITH  
Specialist Registrar  
Accident & Emergency Department  
John Radcliffe Hospital, Oxford

#### Consultant careers

Editor – Many plaudits to Nicholas Morrell and Carol Black for their editorial (*Clin Med JRCPL* May/June 2002, pp185–7) and for bringing into focus the important issue of the need for flexibility and diversity for consultants as they progress through their careers.

Consultant career progression has developed with little formal structure, guidance and support. Furthermore, opportunities for diversification have been largely restricted to medical research, teaching, or management.

Eight years into my post as a consultant rheumatologist, I felt the need for a further challenge and decided to study law. Using my own initiative, time and money, I

undertook an LLB (Honours) course by distance learning. Colleagues hearing of my venture were surprised, and whilst too polite to say so directly, either felt that this was a waste of time or suspected some ulterior motive such as seeking a change of career!

Having completed the course, I acknowledge that it was hard work and intellectually challenging. It required extreme discipline to submit coursework on time. It was also a chastening experience to sit 11 three-and-a-half hour examinations over the four-year period and to write a dissertation (again!). If this experience taught me nothing else, then at least I have revisited what it is to be an undergraduate and hope that I am more sympathetic to my own medical students.

Consultants should be encouraged to diversify. A study of philosophy, literature, art or music may enhance medical practice. The humanities may promote empathy and communication skills by stimulating creative thought and may foster a more enlightened approach towards patients and colleagues. I believe that these attitudes will positively impact upon medical care, job satisfaction and junior colleagues who view consultants as their role models.

I hope that the new appraisal system, under the aegis of clinical governance, will promote a more structured progression for consultants' careers, and wider opportunities for personal development. This is a cause that deserves to be championed by the College.

ASH SAMANTA  
Consultant Rheumatologist  
University Hospitals, Leicester

#### Hospital episode statistics: time for clinicians to get involved?

We do not agree with Williams and Mann<sup>1</sup> that hospital episode statistics (HES) quality is uniformly 'inadequate for the task' and consider that their paper neglects to document the improvements in data quality in recent years. Both English HES, which started in 1987, and Welsh HES (known as PEDW), which began in 1990, experienced initial problems of incomplete admission capture, but studies relating to more recent years show that the accuracy of

HES records has improved<sup>2,3</sup>. Work carried out for the Bristol Inquiry concluded that HES data were of sufficient quality to carry out national comparisons<sup>4</sup>. In particular, HES appeared to record some 99% of 30-day post-operative deaths in hospital<sup>5</sup>. Information on HES quality is now readily available – such as the Data Quality Indicator, a percentage summary figure comprising 13 component indicators, which is available at Trust level<sup>6</sup>. Williams and Mann's observations are based on published literature on data validity but publication bias is likely to operate with data of adequate quality being deemed less worthy of mention.

Problems with data quality are often not uniform but vary by coding field, clinical area, Trust or occasionally region and by year. The approximate agreements in diagnostic coding in one study<sup>7</sup> were quoted as 55% and 72% in two hospitals for a random assortment of diagnoses, but the paper goes on to document agreements of 86% and 91% for specific diagnoses such as asthma. As Williams and Mann highlight, fewer secondary diagnoses and complications are recorded in the UK than in the US, but this is not a good comparison. There is a financial incentive in the US to record co-morbidities more thoroughly, as this may place the patient in a more severe diagnosis related group and bring in more income<sup>8</sup>. Difficulties with comparing data between hospitals or over time may also occur due to variations in diagnostic practices between clinicians, which are independent of the quality of clinical coding<sup>9</sup>.

Quality problems are not confined to hospital data. One quoted study<sup>10</sup> compared cancer admissions with a Cancer Registry but cancer registries are particularly prone to incomplete capture so they cannot be regarded as a gold standard. Death certification does not always agree well with post mortem findings<sup>11</sup>, while in the Framingham study, the death certificate attributed 24% more deaths to coronary heart disease than a review panel of three physicians<sup>12</sup>. In addition, some true underlying causes of death may be under-represented or absent from death certificates<sup>13</sup>.

We agree that a number of issues for HES need to be addressed such as the use of the consultant episode as the building block of