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Travelling for earlier surgical treatment

Sir,

In their uncontrolled observational study (December *Journal,* p.508) Stewart and Donaldson found that patients were keen to travel outside their local health district for earlier straightforward surgical operations. The patients were asked for their views on their return home after surgical treatment. Postoperative complications may occur after discharge from hospital and the study did not take into account the problem of travel to the surgical department when complications arise or for routine follow up. Subsequent referral to the local hospital would lead to difficulties as there may be a lack of detailed information regarding the patient's operative treatment.

Perhaps a more realistic long-term assessment would reveal that patients do not hold such a favourable view of travelling outside their local health district for earlier elective operations. While any initiative to reduce waiting list time is to be encouraged, the proferred solution has limitations and alternatives should be explored.

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Efficient care in general practice

Sir,

Having read Dr Hull's critical review of my book *Efficient care in general practice* (book reviews, February *Journal,* p.86) I can only conclude that he is now remote from the hurly burly of day-to-day and night-to-night frontline urban and suburban general practice which is the continuing task of the great majority of his general practitioner colleagues.

The book is written for these general practitioners as a guide to coping with the great pressures under which they find themselves. By implementing its ideas, I hope their working lives will be more ordered and effective, and that they will be the more able to enjoy the warmth of the doctor–patient relationship which Dr Hull feels is disappearing from British general practice. For him to base this assumption, however, on the results of observations of single-handed Dutch general practitioners working in simple premises and without ancillary help seems to lack the statistical rigour that one would expect from academic general practice. If British general practitioners were to return to that style of care it would undo the great strides forward that group practice and primary health care teams have achieved in the United Kingdom during the last 30 years.

Finally, Dr Hull criticizes my looking at efficiency in general practice from the patient's point of view. Viewing matters from the client's standpoint is now fundamental to the provision of many services in the UK today and is a laudatory step forward in general practice.

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Private health care in the USA

Sir,

The American Medical Association maintains that the United States of America has the best health care system in the world. They clearly have the most expensive health care system, but is it the best?

Technologically it is of a very high standard, yet the life expectancy for American men is rated only 15th in the world and for American women only eighth. Infant mortality rates are rated 20th in the world, and 25 countries have better cardiovascular health. A total of 11.5% of the gross national product is spent on health care yet the people are not as healthy as the Japanese, the Canadians, or the Europeans.[1] In the USA large amounts of money are spent in the private health care system to provide advanced sophisticated health care while the need for immunization programmes, primary health care provision and preventive medicine is ignored.

Thirty one million people are not covered by health insurance and cannot afford to be, and 21% of children under the age of 15 years have no health insurance. Insurance pays for transplants, but not for immunizing all children or providing prenatal care to pregnant women (600 000 women give birth each year with inadequate prenatal care).[1] Similarly, 26% of women of reproductive age are not covered by maternity benefits.[1] This is in contrast to the high standard of care given by health visitors and community midwives in the United Kingdom who will visit mothers to make sure they are recovering well and the baby is thriving.

A lot of the American health care budget is spent on the legal system and bureaucracy.[2] The fear of litigation means that doctors are advised to leave no alternative treatment unexplored, no matter how cost inefficient or how irrelevant it may be to the patient's prognosis and this fear appears to guide medical decisions, rather than doctors' medical training.[3] Doctors choose whatever is deemed beneficial to cover all legal possibilities because of the confusing system.[4] On 3 December 1990 the *US news and world report* stated that in 1990, as much as $200 million may have been spent on unnecessary treatment and 50 000 patients may have died from procedures they did not need.[1]

Modern medicine is dependent on the thorough training of health care providers in judgement skills and in the understanding of disease mechanisms. This will allow them to make the most appropriate treatment decisions for their patients and to provide the support that patients need.

I hope that the National Health Service learns from the mistakes of the American system before it is too late.

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Intrauterine contraceptive device and embryo sharing a bicornuate uterus: corrigendum

In the letter by Dr Furst and colleagues (March *Journal,* p.129) the final sentence should have read '...we suggest that doctors who insert intrauterine contraceptive devices retain the use of the uterine sound for excluding a diagnosis of bicornuate uterus and other uterine abnormalities..' rather than 'the uterine ultrasound'.