Diary

5 October
Harvard Davis Lecture
The Imperial Hotel, Llandudno
Contact: Angela Thomas
E-mail: nwales@rcgp.org.uk
Tel: 01492 877854

8 October
MRCGP Viva Preparation Course
RCGP, Princes Gate, London
Contact: Beverley Russell
Email: brussell@rcgp.org.uk
Tel: 020 7173 6072

12 October
Provost's Annual Awards Event
RCGP, Princes Gate, London
Contact: Beverley Russell
Email: brussell@rcgp.org.uk
Tel: 020 7173 6072

13 October
Reflective Writing Workshop
Leiston Abbey, Suffolk
Contact: Annemarie McCarty
E-mail: eanglia@rcgp.org.uk
Tel: 01223 884324

17 October
Joint Injections half day workshops
Liverpool Medical Institution, Liverpool, L3
Contact: Anna Reid
Email: mersey@rcgp.org.uk
Tel: 0151 708 0865

18 October
Annual Branston Lecture & Dinner
Skiddaw Hotel, Main St, Keswick, Cumbria
Contact: Linda Thorogood
Email: Cumbria@rcgp.org.uk
Tel: 01946 590169

19 October
Gynae Update for GPs — HRT Risks & Evidence Base
Everglades Hotel Derry City
Contact: Ian Feeley
Email: ifeeley@rcgp.org.uk
Tel: 028 90230055

31 October
New Appraiser Skills Training Course
Milton Hill Training Centre, Milton Hill, nr Abingdon
Contact: Sue Daniel
Email: tvalley@rcgp.org.uk
Tel: 01628 674014

Neville Goodman

ATRAUMATIC

There is no perfect health system. All over the world, politicians struggle to make the best of a bad job that gets worse as we become able to do more. Should health care be funded from general taxation? Hypothecated tax? Social insurance? A mixed model? Would charging to visit the doctor help? Look in any general medical journal, or keep an eye on the serious media: these ideas are discussed at length. The evidence of cost-effectiveness of the various models is infinitely interpretable, and no two countries can be properly compared. It is unlikely that we will ever have properly evidence-based health management.

But if you're trying to design a health system it is important that you start off with the right information. You may not need to know which drugs are recommended for hypertension, you can leave that to the clinicians, but you need to have some idea of what sort of a health problem hypertension is: how many people have it; what sort of people have it; whether it is worth treating.

Orthopaedic surgeons have come in for a lot of stick while the NHS has been lurching around for a direction. They have an easily measurable index in the number of people awaiting joint replacement, and there is a perception that by encouraging NHS waiting lists they were feeding their private practices. Joint replacement lists are growing because patients now live long enough to need revisions. During that time they have accumulated enough comorbidities to make the operation a challenge not just for the surgeon. The patients are often ill enough that they would not have been given the primary replacement had they been that ill at that time, but willingness to treat difficult patients has moved on. That doesn't help the growing lists of primary replacements, now also being done in younger patients who previously would have been left until the joint was worse — but prostheses have moved on too. The government is impatient to get all these patients treated, and impatient with the surgeons, who they don't think are working hard enough.

What has this got to do with having the right information to design a health service? One reason the surgeons do too few elective operations is that they are heavily involved with trauma. The surgeon I work with is often in theatre all day screwing smashed pelvises back together. The Department of Health, so I was told, did not realise that orthopaedic surgeons did trauma; they thought it was done by A&E doctors. I wonder under what other misapprehensions the Department is busily reorganising the NHS?