Dear Sir,

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In February 2000, the National Audit Office (NAO) reported that acquired infection of one in every ten hospital patients impedes the recovery of 100 000 patients every year, and kills perhaps 5000 of them, at an estimated cost of £1 billion each year.

In 1995, the Department of Health forecast a 30% reduction of such infection ‘by better application of existing knowledge and realistic infection control practices’. Perhaps £330 million might be saved.

An NAO study in 1996 disclosed that not one of 30 hospitals surveyed had set targets against which to measure health and safety performance. One hundred patients die each week, perhaps 30 of them needlessly, in 219 hospitals. Forty-three of those still have no infection control programme.

‘All the elements that cause or result in such an outcome should be examined.’ The Chief Executive of the NHS has declared to a Parliamentary Committee that it is not for him to do so. No one on the NHS Executive or on a Trust Board is personally accountable for the control of a hazard to health within the scope of COSHH Regulations. Florence Nightingale correlated hospital mortality and sanitation, and Guy’s Hospital has just confirmed that adequate ward cleaning reduces infection.

By default, it is for the Society and the Faculty to consider ways to improve these appalling outcomes, worse than the Southall and Ladbroke Grove disasters together being repeated twice every week. Will they rise to the challenge, and insist upon implementation of the rule of law in the NHS Executive?

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Editor’s reply

I am indeed grateful to Dr Kearns for his comments. It worries me that much time and effort is put into audit and clinical effectiveness work, especially within the NHS, but recommendations are frequently marginalized. We must ask ourselves why this is so. Are they poorly conceived, badly articulated? Are they attempting to serve another agenda? Outcomes are often regarded as the bêtes noirs of occupational health audits. If we undertook more, added a soupçon of economic appraisal perhaps they will achieve more?

Dr Denis D’Auria

Veterans of old wars and recent conflicts in The Netherlands: their long-term psychological adjustment

Dear Sir,

In the last decade, military personnel, particularly those from NATO countries, have become more commonly engaged in military conflicts and peace-keeping duties when they had previously become accustomed to a peacetime role. Therefore, we believe it is timely to revisit the consequences of military conflicts, in order to understand better the occupational risks to today’s military personnel.

Since 1990, we have studied large random samples of Dutch military veterans. The objectives were to investigate long-term psychological adjustment, the determinants of problems of adjustment and the use of health care services. Common methodology was used in all studies, and the different samples were compared for symptoms of post-traumatic stress disorder (PTSD) and their correlates. The studies included:

1. 296 veterans of World War II and/or the Dutch–Indonesian conflict (1945–1950) in a survey of a random sample of 4057 people born between 1920 and 1929 who had all experienced World War II [1].
2. 861 veterans born between 1920 and 1929, with a military disability pension and who were members of the BNMO, an association for military veterans [2].
3. 3496 veterans of peace-keeping operations who had been deployed since 1975 but had left active military service at the time of the study in 1996. This sample included those who served in the Lebanon and the former Yugoslavia [3].
4. 1733 peacekeepers who had been deployed in Cambodia (1992–1993) and participated in a survey [4].

All veterans answered standardized postal questionnaires, including the Self-rating Inventory for PTSD, which reflects the DSM-IV criteria for PTSD [5]. It is a reliable, valid and powerful instrument for diagnosing PTSD in survey research. Exposure to traumatic events was measured using a checklist of events, e.g. ‘being gun-pointed’, with answer categories ‘yes’ and ‘no’. Subjects were not asked to link exposure to trauma with symptoms.

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of PTSD in order to minimize the risk of confounding the stressor and the outcome [6].

Even 50 years later, military veterans had a significantly higher risk for PTSD (7.1%) than males of the same age who had been exposed to wartime stress as civilians (1.7%). Veterans with a military disability pension ran even higher risks for chronic or late PTSD (22.5%). A significant but lower proportion of peacekeepers (between 1 and 5%) had a diagnosis of full PTSD. The same pattern of differences occurred with the proportions of veterans with partial PTSD, i.e. those fulfilling at least one criterion for PTSD. Veterans with higher levels of PTSD symptoms were likely to have additional high scores on anger, anxiety, depression, somatic complaints, feelings of guilt and suicidal thoughts.

The studies show that, dependent on the circumstances during the conflict, a proportion of soldiers will experience long-term psychological effects. Major determinants of these effects include situations involving threat to life, bodily harm, and seeing dead and wounded people. For peacekeepers, risk factors include being taken hostage, feeling powerless, finding the mission pointless and rejection by the local population. Indicators of psychological adjustment immediately following exposure to war and violence were important predictors of long-term morbidity in all samples.

The results may be biased by the retrospective self-report method, making it difficult to disentangle cause and effect. Also, the present state of the veteran may have influenced his reporting of traumatic events [7]. However, there were significant associations between objective indicators of traumatic stress, such as being a veteran or not, and symptoms of PTSD. Our findings also agree with many other studies that found a relationship between both objective and subjective measurements of stress and psychological adjustment. We therefore consider that such a response effect would not be the major explanation for our results.

Altogether, the findings have important implications for soldiers involved in ongoing and future peace-keeping, and/or peace-enforcing operations. These peacekeepers are not only risking their lives, they are also at risk of developing long-term psychological morbidity. To prevent an accumulation of problems in the lives of these veterans and their families, high priority must be given to early detection of psychological symptoms, and to the development of interventions aimed at prevention or alleviation of long-term morbidity.

References


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