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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Why it takes so long to build a hospital

SIR,—Minerva commented on the speed with which Eastbourne's phase II hospital will be built (26 April, p 1141). The main reason for the apparent slickness is twofold. Firstly, we have been constructing access roadways, laying new gas mains, moving old tennis courts since early 1985. This "prephase work" does not count in the timescale. Secondly, a hospital is usually commissioned before it is opened, but locally it has been determined to fudge it and to have our commissioning after the building is completed. Just how it will go is anyone's guess. All that glitters is not gold, therefore, and, allowing for all these devices, Eastbourne's phase II will take more than four years to complete.

These delays and devices are, however, as nothing when compared with those perpetrated during planning of Eastbourne's phase II. Phase II was initially planned to start in 1975, with completion in 1978. At that time neither the Hastings nor the Hove hospitals had been considered. In Eastbourne planning eventually started in October 1978, and governments (of various hues) delayed the process by at least two and a half years—the same politicians who complained about the slowness in reaching decisions in the NHS.

Firstly, the DHSS demanded a survey into why phases I and II would total more than 600 beds after 600 beds had been declared the norm. The 700 odd complement was eventually accepted—but only after the project had been halted—when it was pointed out that with the original progressive care module (now gone along with Salmon and, we hope, the nursing process) all the beds could not be used as envisaged in the 600 bed model.

Secondly, the Treasury required an investigation into the revenue gap—that is, the difference between the savings released by closing hospitals and the cost of running the new one—which, unless it is to be substandard like the old one, will cost more. This was a very proper request and well

understood because we also did not want to be unable to afford to run phase II. It was so well understood that we had estimated the gap as at least £215 000 revenue, and, by good house-keeping, the district management team had (without a manager in sight) salted away that amount (using it for non-recurring purposes year on year) and was prepared to bridge the balance (if any) by defined savings. You would think the question had been answered; not at all, region and area (this was in 1980-1) could not agree the size of the gap. The range was £140 000 to £470 000 and the amount fluctuated up and down like a yoyo—something like RAWP targets today. Planning was held up until they concluded it was probably (but all agreed that it was not possible to be certain) around £190 000—well covered by our original guesstimate.

Thirdly, the Treasury insisted that all new hospital projects must have an option appraisal. Quite correct—it should be mandatory if starting from scratch: no one wants a hospital to be built in the wrong place. The DHSS, however, would not accept that Eastbourne had already carried out its appraisal in 1967-9 before phase I. After phase I was completed in 1976 any options about siting phase II elsewhere had been pre-empted. Nevertheless, another sterile exercise, wasting money and halting the planning, had to be gone through. In 1983 the DHSS was finally satisfied that phase II conformed to design guidance and that alternative options had been appraised.

Each delay had the effect of further slowing down the planning work. For example, after a six month shutdown the engineers and architects had been redeployed to another project and their replacements took a few months to bed in. Each delay also added to the costs of maintaining the old hospitals due for replacement. If the timetable was to be 10 years instead of seven before the change-over, an upgrading or rewiring might become

necessary. Thus all these well intentioned, but unnecessary, measures were inflicted on patients and staff, simply because of the inflexible application of policies which may well apply to Sainsbury but need severe honing before use in the health service.

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Measurement of amylase activity—a useful indication of tissue damage after major radiation accidents?

SIR,—The recent Chernobyl radiation accident prompts me to draw attention to a paper published in your journal in 1982.¹ In this paper we reported rapid and very considerable (up to 40-fold) increases in serum amylase activity after exposure to high level radiation doses before marrow transplantation. The amylase activities reached their peak within 12-36 hours, returning to normal within 17 hours in most cases, and the increase was almost entirely due to the rise of salivary isoenzymes. The biochemical changes were associated with swelling of the parotid gland, dry mouth, and loss of taste. Our findings were fully confirmed by a recent study, which put an even greater emphasis on the contribution of the salivary amylase.²

Previous papers on the same subject showed a similar amylase activity pattern after irradiation (Stamm A *et al* and Lloyd DC, Seventh International Congress on Radiation Research, 1983), and Chen *et al* for instance showed that 1-3 Gy doses to people with their salivary glands in the field produced a 12-fold increase in serum amylase activity.³ But the impetus to provide a reliable and practical early biochemical indicator of post-