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A list of resolutions passed by this year's annual representative meeting appears between pages 568 and 569 or between pages 572 and 573

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Editor's Choice

Challenging orthodoxies

The orthodox line on thrombolytic therapy for suspected myocardial infarction is that patients should get themselves to hospital as soon as possible because general practitioners are not well equipped to administer such treatment. J M Rawles and his colleagues show, however, that—at least around Aberdeen—general practitioners can provide successful prehospital care of patients with myocardial infarction, including thrombolysis (p 548). Showing that it is possible to confound the sceptics in this way should also encourage readers of two other articles: Hugh Thomas and Roger Humphrey argue that it is easily possible to increase the rate of day surgery for cataracts (though it might need more ophthalmologists) (p 536), while the Thromboembolic Risk Factors Consensus Group want to see more surgeons and physicians routinely using prophylaxis against venous embolism (p 567).

Challenging another sort of orthodoxy, Catherine Pope argues that the simplistic emphasis on cutting long waiting times in the patient's charter ignores most recent research into waiting lists (p 577). Some of this suggests that waiting lists don't behave like queues at all but like pools and that increasing the numbers of consultants will simply increase the lists. Another area where rhetoric conflicts with reality is highlighted by Allyson Pollock in our first editorial (p 535): she argues that the current emphasis on consulting citizens about what they want from their health service draws attention away from the fact that democratic accountability in the NHS is less than ever before.