

General Medical Council). It cannot be taken away by a monopoly employer or monopoly administration.

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1 No smoke without fire. *BMJ* 1993;307:1075. (23 October.)

## Care of suicidal prisoners

EDITOR,—Having inspected 100 or so prisons in the penal estate of England and Wales and having been responsible for most of the medical recommendations coming from HM Inspectorate of Prisons over the past few years, I think I should comment on the letters of Rosemary Wool, Mary Helena Rowlands, and William A Hart.<sup>1</sup>

Surprisingly, any terminological confusion which may have arisen from the article of Alison Liebling and Peter Hall<sup>2</sup> is nothing new. The assessors at the inquiry after the Barry Prosser incident at Birmingham also found it extremely difficult to find a definition of these particular sorts of cells, and that confusion still exists.

I always felt that if a patient was psychiatrically ill he should not be put into a solitary cell, whether it be protective or unfurnished in a prison medical centre. Conversely, if a patient was not ill he should not be coming into the prison medical centre. Despite Wool's protestations, the use of unfurnished rooms persists, even where there are no night staff in the hospital. In one prison the hospital officers did not know of the form required for documentation when a person is retained in such a protective or unfurnished room overnight, what time he went in, who authorised it, and what time he got out. In fact, that form is very seldom used.

A person held in an unfurnished or protective room should be observed at 15 minute intervals. That, of course, is impossible if there are no night staff to do it. It is well known that there have been incidents of suicide under these conditions in prisons in between the observations. Any statistics on the use of "unfurnished" rooms across the 130 prison establishments have no statistical significance at all because in many cases the forms are simply not filled in.

Recently I saw a prison where the F220 for self inflicted injuries showed only three incidents over the past two years. If that was true it must be the most unusual prison in the whole of the country.

After seven years of looking at the medical situations in British prisons I have seen few good arguments for using protective or strip cells in prison hospitals, especially when there were no full time medical staff and where there are no night staff.

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1 Correspondence. Care of suicidal prisoners. *BMJ* 1993;307:805. (25 September.)

2 Liebling R, Hall PP. Seclusion in prison strip cells. *BMJ* 1993;307:399-400. (14 August.)

## Giving intravenous drugs

EDITOR,—We commend K Teahon and D N Bateman's approach to improving preregistration house officers' technique in giving intravenous drugs.<sup>1</sup> The authors should have emphasised, however, that doctors should check for drug allergies before giving intravenous drugs, particularly antibiotics. Patients often do not associate intravenous treatment with allergies to tablets. We have seen patients develop severe allergic reactions while on the way to the operating theatre after

receiving prophylactic ampicillin intravenously despite having a known allergy to oral penicillin.

We teach safe administration of intravenous drugs in our "practical skills laboratory," which is part of the four week module on anaesthesia and intensive care for final year medical students at the Chinese University of Hong Kong. This module has been developed over the past five years and teaches practical skills in readiness for the intern (house officer) year. These skills include intubation, intravenous cannulation, administration of blood products, "safe intravenous sedation," and the management of multiple trauma. Recently we have enhanced our teaching with video recordings of various clinical procedures, and we strongly recommend their use and the development of practical clinical skills laboratories to all medical schools.

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1 Teahon K, Bateman DN. A survey of intravenous drug administration by preregistration house officers. *BMJ* 1993;307:605-6. (4 September.)

## Eradication of leprosy

EDITOR,—Minerva comments "that resistance to dapsone is now widespread" and implies that there is limited money for multidrug therapy.<sup>1</sup> These statements do not reflect the current optimism about eradicating leprosy by using chemotherapy. Dapsone monotherapy has led to a dramatic fall in the incidence of the disease in spite of resistance,<sup>2,3</sup> and now with multidrug therapy the World Health Organisation predicts that leprosy will not be a public health problem by the year 2000.<sup>4</sup> Only \$420 million is needed to achieve this aim.<sup>5</sup> India, Indonesia, and Myanmar account for 70% of existing cases, and their governments have made eradicating leprosy a priority.<sup>5</sup>

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1 Minerva. *BMJ* 1993;307:812. (25 September.)

2 Crawford CL. In spectacular retreat. *BMJ* 1990;300:261.

3 Crawford CL. Controlling leprosy. *BMJ* 1992;305:774-5.

4 World Health Organisation. *Leprosy elimination: meeting the challenge*. Geneva: WHO, 1993. (WHO/CTD/LEP/93.2.)

5 Mangla B. Leprosy vaccine debate in India re-ignited. *Lancet* 1993;342:233.

## Altered inflammatory responses in smokers

EDITOR,—C M Mills and colleagues report that cutaneous microvascular responses to a variety of stimuli are abnormal in heavy smokers.<sup>1</sup> They comment that more than one factor may operate to produce these effects. Of particular interest is the reduction in the hyperaemic response that follows occlusion of the brachial artery in smokers compared with non-smokers. Hyperaemic flow in large vessels stimulates the release of endothelium derived relaxing factor, an important modulator of vascular tone. By measuring arterial diameter non-invasively Celemajer *et al* showed that dilatation of the superficial femoral artery in response to hyperaemic flow is reduced in smokers; they postulated that the endothelium of smokers may be functionally impaired.<sup>2</sup> We have shown that the venous endothelium of heavy smokers has a reduced capacity to produce endothelium derived relaxing factor, both in organ bath studies measuring

vasorelaxation and in vein culture studies analysing levels of the oxidation products of endothelium derived relaxing factor.<sup>3</sup> Dilatation of the vasculature at the level of both large vessels and precapillary arterioles has been shown to be influenced by endothelium derived relaxing factor.

One explanation for the altered cutaneous hyperaemia in smokers is that responses that depend on the endothelium are impaired, resulting in a reduced capacity for the limb vasculature to dilate. Our studies have shown that smokers have to stop smoking for several months before relaxation that depends on the endothelium in the saphenous vein is restored to that observed in non-smokers. It would be interesting to investigate whether a similar restoration of cutaneous hyperaemic flow occurs after people have stopped smoking.

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1 Mills CM, Hill SA, Marks R. Altered inflammatory responses in smokers. *BMJ* 1993;307:911. (9 October.)

2 Celemajer DS, Sorensen KE, Gooch VM, Spiegelhalter DJ, Miller DO, Sullivan OD, *et al*. Non-invasive detection of endothelial dysfunction in children and adults at risk of atherosclerosis. *Lancet* 1992;340:1111-5.

3 Higman DJ, Greenhalgh RM, Powell JT. Smoking impairs endothelium-dependent relaxation in saphenous vein. *Br J Surg* 1993;80:1242-5.

## Pass rate in MRCGP examination

EDITOR,—Our paper on pass rates in the membership examination of the Royal College of General Practitioners (MRCGP) presented aggregate pass rates for trainees born in the United Kingdom or the Republic of Ireland who were taking the examination for the first time.<sup>1</sup> T Stuart Murray and colleagues criticise the league table of regions of postgraduate training on the grounds that the number of those eligible to take the examination from each region should have been the denominator for the comparisons rather than the number who actually took it,<sup>2</sup> on the basis that "in regions where fewer trainees sit, it will inevitably be the stronger candidates who take the exam."<sup>3</sup> H L A Houston and colleagues criticise the league table of medical schools on the grounds that to produce graduates who will pass such an examination is not an aim of medical schools.<sup>4</sup>

League tables have misleading aspects—hence our caveats—including the issue of differential regional "take rates." We question the scientific logic of using the nearest proxy to the unknown number of those eligible to sit the examination—namely, the numbers of certificates of satisfactory completion of training issued by the Joint Committee for Postgraduate Training in General Practice—as the denominator.<sup>2</sup> We gave reasons why the joint committee's data are unsatisfactory for this purpose. That they are unsatisfactory is shown by the fact that in one of the years used to construct Murray and colleagues' proposed alternative league table the number of trainees from the west of Scotland who sat the examination was far higher than the reported number of certificates of satisfactory completion of training issued—a take rate of 123%, and an overall take rate for the three years of 103%.<sup>2</sup> By no means do all trainees in the west of Scotland take the examination. The alternative league table is thus invalid.

We know of no evidence to support the assertion that in regions in which fewer trainees sit the examination it is the more able ones who do so, and we do not share Murray and Whiting's intuition that this is the case.<sup>3</sup> We do not know of any regions which select their candidates; the decision to take the examination is taken by the person concerned.

We question what improvement in the data is afforded by treating those who do not sit a voluntary examination as equivalent to those who enter and fail it.

In the emerging atmosphere of higher education, in which quality and value for money are watchwords, funding bodies are increasingly using performance indicators. Such indicators include numbers of staff and students; school leaving qualifications; drop out rates; quality of educational provision; pass rates; measures of graduates' subsequent success; and excellence and productivity of research. Data on many of these have been published or made available to universities, and they provide material for reflection—for example, one of us has reported substantial differences in the clinical experience provided by groups of medical schools (London, Oxford and Cambridge, England and Wales, Scotland and Northern Ireland).<sup>7</sup>

Medical education is a continuum from undergraduate training through to continuing medical education. One object of undergraduate training is to prepare students for postgraduate training, which is typically assessed at some point by the examinations of the royal colleges. Measures of success in medicine are thus likely to include the results of these examinations, and we do not think that this is inappropriate. To this end it is desirable that all royal colleges publish data on the performance in their examinations of British graduates by medical school.

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## Performance indicators in general practice

EDITOR.—Stephen H H Sylvester suggests that postgraduate accreditation is acceptable to general practitioners, at least on an occasional basis.<sup>1</sup> I conducted a survey of general practitioners' attitudes to another form of quality assurance: performance indicators.<sup>2</sup> A performance indicator is a measure of an aspect of clinical activity that can

be used to monitor the quality of primary care on an ongoing basis.

A questionnaire was posted to all general practitioner trainers in a district of Scotland during April 1992; 31/33 (94%) responded. Most (20; 64%) doctors supported increasing quality control in general practice. The doctors were also asked to express the extent of their agreement with statements about seven performance indicators meeting each of 10 criteria mainly derived from the literature.<sup>3,4</sup> A high proportion of doctors thought that immunisation and cervical smear rates were important and acceptable quality measures (table). Unfortunately, these preventive measures were omitted from the aspects of work for scrutiny under reaccreditation in Sylvester's study, but attitudes to patient satisfaction and referral rates, which were covered by Sylvester, were remarkably similar in both studies. As a performance indicator, patient satisfaction was judged to be important by virtually all doctors but was considered to be an acceptable quality measure by just under half of the sample. Referral rates were judged to be important or acceptable by only a small proportion of doctors (table).

Despite the acceptance of the need for quality control, few of the indicators were felt by the majority of doctors to be valid for comparison within or between practices or to be useful for resource allocation. In Sylvester's study only a small number of respondents agreed that reaccreditation would lead to better value for money from doctors. Both studies suggest that general practitioners are happy with quality initiatives as a part of continuing education. These doctors were less sure, however, about the role of these mechanisms within the internal market.

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## Waiting list times for treatment

EDITOR.—I do not wish to debate the merits or otherwise of the decision of West Midlands Regional Health Authority to publish waiting times for treatment by individual consultants.<sup>1</sup> I do wish, however, to draw attention to the model of a "common" waiting list which can ensure an equitable service and may produce a saving in resources.<sup>2</sup> This model proposes that waiting lists at hospitals should be kept in chronological order by specialty rather than by individual surgeons, certainly for the common conditions that form the bulk of a surgeon's workload.

Annual consultations with general practitioners in South Tees Health District have elicited few objections to such a model (personal observations). In addition, support for the model was obtained

during a retrospective review of two common operations (repair of inguinal hernia and arthroscopy of the knee). This review showed that there was relatively little difference in the severity of cases between the different surgeons in the teams and that many of the operations were done by middle grade staff.<sup>3</sup> Of course, referrals have to be made to a specific consultant sometimes—for example, if that consultant has a special interest or a patient has a particular preference. This, however, occurs relatively rarely.

The reason given for long waiting lists is lack of resources. Until further resources become available all health care professionals must ensure that the resources they have are used judiciously. In addition, putting patients of fundholding and non-fundholding general practitioners on the same chronologically maintained waiting list would eradicate the increasingly two tiered nature of the NHS. The model of a common waiting list goes some way to solving this complex issue; it should therefore be considered.

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## Marketplace model is destructive of NHS

EDITOR.—I was grateful to Rudolf Klein for shining a discerning light on the delusory proposals by National Economic Research Associates for a global health care package.<sup>1</sup> He points out that the reasonable and seemingly practical suggestion for a health marketplace in Britain has not produced the anticipated better breed of NHS. Why not?

Perhaps the solution is something fundamental in human nature. All activities of people could be seen as being features of one of two dichotomous models: the family and the business. The family (or club or culture or kingdom) depends for its existence on sharing, caring, creativity, altruism, honesty, etc. It values virtues and dedication because without them it would cease to be. Activities slotted into this model produce mutual satisfaction because they serve only one interest.

The business model describes the interaction between two families (or clubs, cultures, or kingdoms). It values sharpness, wit, cunning, and diplomacy. It serves two interests and is relieved when both concur. It is, however, willing to create conflict and hardship when those interests clash. It is even willing, strangely, to see the destruction of the family rather than the subjugation of its interests. Frederic Ozanam (1813-53) summed it up well: "The question of which divides men nowadays is no longer politics... it is whether society is a great exploitation to the profit of the strong, or a consecration of every man for the

Number (percentage) of general practitioners who agreed or strongly agreed with criteria of quality control on seven performance indicators

Criterion	Immunisation rates	Cervical smear rates	Prescription rates	Patient satisfaction	Consultation time	Waiting time	Hospital referral time
Important aspect of care	25 (81)	24 (77)	10 (32)	28 (90)	21 (68)	20 (64)	9 (29)
Acceptable measure of quality	19 (61)	16 (52)	7 (23)	15 (48)	8 (26)	11 (35)	5 (16)
Simple to collect	30 (97)	29 (93)	30 (97)	4 (13)	12 (39)	5 (16)	23 (74)
Unambiguous to the GP	24 (77)	23 (74)	13 (42)	4 (13)	7 (23)	7 (23)	12 (39)
Improvement within control of GP	29 (93)	26 (84)	20 (64)	10 (32)	19 (61)	15 (48)	13 (42)
Valid for comparison between practices	9 (29)	10 (32)	19 (61)	9 (29)	9 (29)	11 (35)	17 (55)
Valid for comparison within practices	15 (48)	14 (45)	10 (32)	8 (26)	7 (23)	10 (32)	7 (23)
Useful for resource allocation	11 (35)	10 (32)	8 (26)	4 (13)	4 (13)	4 (13)	6 (19)
Not open to misinterpretation by management	16 (55)	17 (55)	7 (23)	6 (19)	6 (19)	8 (26)	4 (13)
Useful for running of practice	25 (81)	25 (81)	14 (45)	29 (93)	18 (58)	20 (64)	14 (45)