who had had a stroke and 24% of able bodied controls failed a mock driving test.¹

SURESH KEETARUT

Clatterbridge Driving Assessment Centre
for the Disabled,
Clatterbridge Hospital,
Bebington,
Wirral,
Merseyside L63 4JY

- 1 Frier BM. Driving and diabetes. *BMJ* 1992;305:1238-9. (21 November.)
- 2 Saunders CJP. Driving and diabetes mellitus. *BMJ* 1992;305:1265. (21 November.)
- 3 Transport Research Laboratory, Department of Transport. *Digest of contractor report 276*. London: DoT, 1992.

Distinguishing inhalers to aid blind people

EDITOR,—The need for distinguishing features to be displayed on metered dose inhalers¹ has not gone unnoticed. Two years ago Norton began embossing Braille on the carton of dispensed packs, with a simple statement as to the contents. We began with our salbutamol metered dose inhaler carton and moved on to products in blister packs.

Recently our attention has been drawn to the problem of the partially sighted differentiating metered dose inhalers. It would be impossible to include the full wording in the space available for the embossed message on an actuator. A permanent engraving has been suggested for the tooling, but the same tool is used for different products. One solution would be, as David Maxwell suggests,¹ for a symbol or single Braille letter to be agreed by the Department of Health, the drug manufacturers, and the Royal National Institute for the Blind.

Our suggestion would be for an initial letter in Braille to be put at the top left hand corner of the actuator and the strength in the other top corner. For example, the initial letter could be: salbutamol=A, beclomethasone dipropionate=B, sodium cromoglycate=C, etc. The strength area for salbutamol would be blank while that for beclomethasone would show, in Braille, a number corresponding to the strength in that range: low=1, medium=2, high=3.

We have already contacted some of the interested parties about this suggestion and would be grateful for comments or suggestions.

DEREK C HOYE

H N Norton,
Harlow,
Essex CM19 5TR

- 1 Maxwell D. Distinguishing inhalers to aid blind people. *BMJ* 1992;305:1226. (14 November.)

Medical education

EDITOR,—Having trained in Britain, I am now gaining a Caribbean and American perspective as executive dean of an "offshore" medical school. In the first article in her series Stella Lowry asks what is wrong with medical education in Britain.¹ The problem seems to be not with medical education, the curriculum, or the teachers but with the structure of the medical schools. In a closed system they have grown used to having many applicants for few places. The future and performance of their graduates are of no concern to them. House jobs and higher posts are all largely in their gift. I think that this has played a large part in the disillusionment of newly qualified doctors and the loss of interest in medicine as a career among school leavers.

The situation at Ross University Medical School, an offshore school for American citizens, is different.

The goal of the basic science campus is to prepare our students for the United States medical licensing examinations—specifically, step 1. If our pass rate is low we will have difficulty attracting students, getting federal loans for them, and finding American hospitals in which they can do their clinical rotations. If our students do poorly in their clinical rotations we will have difficulty placing further students in that hospital. The better their scores in the United States medical licensing examination the better residencies they will obtain. The better our graduates do in finding residencies and fellowships the better students we can attract to the school. The performance of our students is crucial to the school's survival.

Britain does not have a comparable system. There is no national examination. External examiners from another school merely perpetuate the cosy status quo, whereby what happens to graduates and their quality are of little interest to the schools.

If the General Medical Council administered a national licensing examination and the schools' results were published the schools would be more purposeful and concerned. The council would also have a chance to influence the quality and scope of medical education.

PHILIP COOLES

Ross University Medical School,
PO Box 266,
Roseau,
Commonwealth of Dominica,
West Indies

- 1 Lowry S. What's wrong with medical education in Britain? *BMJ* 1992;305:1277-80. (21 November.)

EDITOR,—Medical student selection is a difficult area in which to introduce change, but Stella Lowry's article¹ was too nihilistic.

The argument advanced, that there are so many and varied opportunities after graduation that selectors should not agonise too much about choosing the "right sort" of candidate, is the height of complacency. Companies invest large sums of money in selecting the right people because it makes good business sense.

The author acknowledges that selecting medical students has more lasting implications than for other university courses. The fact that it is difficult does not mean that we should not strive to improve it.

In 1989 Alan Porter and I pointed out that very little of the information on an UCCA form (the only shortlisting information available) has predictive validity for clinical performance.² A level results are usually only predicted; the head teacher's report is hardly impartial; and the applicant's "interests" are often tailored as a result of coaching by careers teachers. Medical students are often immature and ill prepared for the traumas of medical training, as illustrated recently in the television series "Doctors to be."

One immediate partial solution would be to permit application only after completion of A levels. Applicants would be more mature and have an opportunity to show the use to which they had put the available time. The A level results would be real rather than predicted. Motivation towards being a doctor would be tested by the enforced year's delay. It has the added advantage of zero cost. Implementation would clearly have to be phased.

Further research into the predictive validity of a whole range of information would be useful. Biographical details (biodata) have been shown to be useful in some studies in the United States.³⁻⁶ Selection by desired learning styles is of interest, but should wait until we have achieved desired teaching styles.

GEOFF ROBERTS

Camberley,
Surrey GU15 2HJ

- 1 Lowry S. Medical education: student selection. *BMJ* 1992;305:1352-4. (28 November.)
- 2 Roberts GD, Porter AMW. Medical student selection: time for change. *J R Soc Med* 1989;82:288-91.
- 3 Ambrosino RJ, Brading PL. An analytical computer-based methodology for screening medical school applicants. *Journal of Medical Education* 1973;48:332-5.
- 4 Best WR, Diekema AJ, Fisher LA, Smith NE. Multivariate predictors in selecting medical students. *Journal of Medical Education* 1971;46:42-50.
- 5 Haley HB, Juan IR, Paiva RE. MCAT scores in relation to personality measures and biographical variable. *Journal of Medical Education* 1971;46:947-58.
- 6 Rabinowitz HK. A program to recruit and educate medical students to practice family medicine in underserved areas. *JAMA* 1983;249:1038-41.

EDITOR,—Stella Lowry concludes her article on student selection by saying that "we must encourage more applicants by reversing recent negative images of medicine as a career."¹ As long as this government is intent on a market led society, fundholding, hospital trusts, and two tiers of medical care is it surprising that candidates who are caring and have the "right" attitudes to enter medicine are now shunning the profession?

I entered medical school in 1961, an idealist and great supporter of the NHS principle that good health care is for all and independent of a patient's means. I still believe that the whole community should be able to have access to the best care. Unfortunately this is not so. I recently found out that a patient of mine could not undergo coronary artery bypass grafting because the health authority had spent its allocation for this operation—a decision made by an administrator who did not take into consideration the patient's clinical needs. Is this progress? Is this the NHS that the country wants? I am sure not, and that is why students are looking elsewhere for job satisfaction.

B OLSBURGH

Health Centre,
Whitley Bay,
Tyne and Wear NE26 2ND

- 1 Lowry S. Student selection. *BMJ* 1992;305:1352-4. (28 November.)

Dangers of review articles

EDITOR,—T J Parke and colleagues' paper reporting fatal complications of propofol infusions used for long term sedation in five children raises a question.¹ Recent surveys from both the United Kingdom² and Norway³ have shown widespread use of propofol in paediatric intensive care units. What is the scientific background for this unapproved use? To our knowledge there have been only six case reports on the use of propofol for long term sedation of children in peer reviewed journals, and three of them contain warnings of possible side effects.⁴⁻⁶

Now that doctors are exposed to almost overwhelming amounts of medical information, review articles and review journals have gained popularity as sources of clinically useful information. We therefore looked for data on sedation in children in the latest issues of two widespread review journals, *Current Opinion in Anaesthesiology* and *Current Pediatrics*.^{7,8} Both suggested using propofol for long term sedation in children. This is despite the warning against this published by the manufacturer in the *British Journal of Anaesthesia* in 1991.⁹ One review contained no references at all, only the authors' unpublished experiences.⁷ In the other review the recommendation was based on three case reports, not all from peer reviewed journals.⁸ We do not believe that this would have been accepted in an international peer reviewed journal.

Knowing how much busy clinicians depend on reviews of published work, we find the acceptance of long term use of propofol in such review articles alarming. Ten years ago another short term anaesthetic, ethmoidate, was used without a product