the first is presumably a consequence of migration patterns, but is the second correct? Among Bangladeshis there are apparently three times as many men as women in the older age groups both in Greater London and in the rest of England while there are fewer men than women aged 35-54. One could speculate as to how this might have arisen, but underreporting must be a possible explanation. Among Pakistanis there are more men than women aged 55-79. Again, this might be correct or a consequence of underreporting.

The point is simple: while there are good grounds for supposing underreporting by ethnic minority groups, it is not clear that this is confined solely to Afro-Caribbeans or to Londoners. Given that deprivation scores are currently used to calculate each of the component scores relative to a national average, the case for a specific adjustment in London is doubtful.

ROY A CARR-HILL

Centre for Health Economics,
University of York,
York YO1 5DD

- 1 Glover GR. Sex ratio errors in census data. *BMJ* 1993;307:506. (21 August.)
- 2 Thompson EJ. Underenumeration in 1991 census. *BMJ* 1993;307:803. (25 September.)

Forms not retrieved

EDITOR,—Two letters have drawn attention to underenumeration in the 1991 census.^{1,2} The importance of establishing the degree of underenumeration of the resident population in health districts in inner London prompted my department to include in a local health survey a question about respondents' completion of a census form. Given that non-completion of a census form is illegal, ascertaining the extent of possible census underenumeration in the census posed a methodological challenge for the survey's designers. In the study respondents were asked if their census form had been collected. This would identify two potential sources of underenumeration: the failure of respondents to complete a census form and the failure of census enumerators to collect completed forms.

The survey was undertaken in the eight wards of the former Parkside District Health Authority with a standardised mortality ratio ≥ 110 ; a total of 821 interviews were carried out, giving a response rate of 77% (821/1059). Overall 64 (8%) respondents reported that their census form had not been collected. The table shows that non-collection of a census form was most likely to be reported by respondents aged 16-34 and by respondents from ethnic minorities.

These data suggest that the 1991 census may have greatly underenumerated the population that

Details of respondents to survey and of those reporting non-collection of census form

	No of respondents	No (%) reporting non-collection of census form
Age (years)*:		
16-24	85	10 (12)
25-34	219	28 (13)
35-44	149	13 (9)
45-54	91	8 (9)
55-64	113	2 (2)
≥ 65	154	3 (2)
Sex†:		
Male	282	22 (8)
Female	530	42 (8)
Ethnic group:		
White	497	30 (6)
Black	191	13 (7)
Asian	33	4 (12)
Other	71	10 (14)
Not stated	29	7 (24)

*Data on age were missing for 10 respondents.

†Data on sex were missing for nine respondents.

is resident in inner cities and in particular may have failed to enumerate many people from all those ethnic minorities. This underenumeration may result in underfunding of district health authorities in inner cities, and use of inaccurate population denominators may artificially inflate the prevalence of disease and rates of use of services.

CHRISTINA VICTOR

Department of Public Health,
Kensington and Chelsea and Westminster
District Health Authority,
London W2 1PF

- 1 Glover G. Sex ratio errors in census data. *BMJ* 1993;307:506. (21 August.)
- 2 Thompson EJ. Underenumeration in 1991 census. *BMJ* 1993;307:803. (25 September.)

Malaria prophylaxis

Mefloquine should be first choice

EDITOR,—We are surprised that J C F M Wetsteyn and A de Geus felt able to reach any conclusion on the basis of their study four to six years ago of various chemoprophylactic regimens against malaria, all of which included proguanil.¹ They seem to acknowledge that their study lacked adequate power, with only 12 confirmed cases of falciparum malaria distributed among the three arms of the trial and correspondingly wide confidence intervals. Similarly, the number of adequate specimens was too small to provide useful data on compliance. The authors' confident assertion of the low overall risk of failure of prophylaxis is based on the examination of single thick blood films prepared by the subjects—a method of unknown sensitivity. Some subjects who developed fever might have been disinclined to comply with this procedure and consequently become non-respondents.

The authors' recommendation for the continued use of chloroquine-proguanil combinations for travellers to Africa flies in the face of results of recent comparative studies, which have shown mefloquine to be superior. For some time we have expressed the view that it is unsatisfactory to recommend chloroquine-proguanil when mefloquine is not contraindicated, particularly for visitors to areas of multiple drug resistance such as east Africa.² This view is now reflected in the most recent guidelines of a committee of British experts on malaria,³ who had previously been the main champions of chloroquine-proguanil. Wetsteyn and de Geus provide no evidence to contradict our view.

G BAILY

I S FRASER

E M DUNBAR

E G L WILKINS

Regional Department of Infectious Diseases
and Tropical Medicine,
Monsall Hospital,
Manchester M10 8WR

- 1 Wetsteyn JCFM, de Geus A. Comparison of three regimens for malaria prophylaxis in travellers to east, central, and southern Africa. *BMJ* 1993;307:1041-3. (23 October.)
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Authors' reply

EDITOR,—Our study was designed to compare the efficacy of three regimens for malaria chemoprophylaxis, particularly two chloroquine-proguanil combinations. We did not compare chloroquine-proguanil with mefloquine.

G Baily and colleagues question our methods.

Malaria infection during travel is not usually confirmed parasitologically.^{1,2} The participants in our study were carefully instructed what to do if they developed fever; this included making two thick blood films and filter paper bloodspots themselves. As 54 of the 58 blood films were examined in our laboratory in Amsterdam we know that the sensitivity of this method is high. The response rate among the subjects who developed fever was over 90%.

Fifty eight (5%) of the 1421 travellers with a fever sent a blood film. This proportion is higher than the 2% (15/767) of travellers to east Africa reported by Fogh *et al*, who used the same method.³ Fogh *et al* found the rate of failure of prophylaxis to be 0.9%, which corresponds with our rate of 0.8%. Our figures on the risk of prophylaxis with chloroquine-proguanil failure were similar to those found for various prophylactic drugs by means of self administered questionnaires.^{1,2}

The failures of prophylaxis in our study overestimate the resistance of *Plasmodium falciparum* to the drugs used as we estimated that about half of the participants in our study were compliant. This percentage accords with other studies.^{1,2}

Our study was indeed performed four to six years ago. There is no indication, however, that resistance has become more severe in east Africa recently.⁴ In our hospital in Amsterdam the number of patients with malaria resistant to chloroquine using the chloroquine-proguanil combination has been stable since 1984. The data on the protection given by the chloroquine-proguanil combination in our study is supported by published reports.^{1,3} We have found that patients suffering from falciparum malaria despite compliance with chloroquine prophylaxis are usually protected from severe complications. Death is almost always due to delay by the doctor or patient.

We agree with Baily and colleagues that mefloquine is superior to chloroquine-proguanil in areas with high transmission of multidrug resistant *P falciparum*, such as west Africa. For this reason the National Health Authority in the Netherlands recommends prophylaxis with mefloquine for people visiting west Africa for a short time. The incidence of malaria in travellers not taking prophylaxis is 1.5 times higher in west Africa than east Africa.²

J C F M WETSTEYN

A DE GEUS

Department of Infectious Diseases,
Tropical Medicine, and AIDS
Academic Medical Centre, F4-222,
1105 A2 Amsterdam,
Netherlands

- 1 Lobel HO, Philips-Howard PA, Brandling-Bennett AD, Steffen R, Campbell CC, Huang AY, *et al*. Malaria incidence and prevention among European and North American travellers to Kenya. *Bull WHO* 1990;68:209-15.
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Total quality management

EDITOR,—In modern revolutions which building do the rebels seize first? The royal palace? The houses of parliament? No. It is the television centre that holds the keys to the city: language is power. If you can control the dissemination of language you will win (as in the general election of 1992).

The organisation of medical care in Britain is

undergoing a revolution. The economic stranglehold on the NHS is shifting power from doctors to administrators (the change to the new term "manager" exemplifies this). Fifteen years ago in discussions between doctors and administrators the bottom line was clinical need; the decisive language was therefore medical and the administrators had to bow to the clinicians. Now the bottom line is cost, the decisive language is financial, and therefore clinicians must bow to managers.

Total quality management has to be seen in the context of this battle. Do not be fooled by the fact that some of the leading advocates of total quality management are doctors. They are playing a dangerous game, hitching a ride on the tanks of the rebels as they enter the city, hoping to outmanoeuvre their colleagues.

Hart states that "quality management should ensure lower surgical complication rates, fewer unplanned readmissions, and safer treatments."¹ The unfortunate implication is that before the introduction of total quality management these aims (that is, safe, effective treatment) were not part of normal medical practice. Perhaps it is stating the obvious, but the aim of medical education is to produce safe, effective doctors.

The question at the heart of the matter is who should make the final decisions on medical care. Doctors (before 1948)? The state guided by health professionals (1948-89)? The state alone (1989 onwards)? The bottom line being cost, the state and its lieutenants must hold the citadel. Fair enough. But to dress this up as a quality exercise is an abuse of language worthy of George Orwell.

P HOLMES

London SE3 7HX

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Clinical freedom and drug dependence

Treatment of American was legitimate

EDITOR,—It is unfortunate that John Strang and Michael Farrell¹ suggest pandering to American prohibitionist fundamentalism in exactly the same way that led Willis to bemoan the demise of the British System (practice recommended by the Rolleston committee of the Ministry of Health in 1926);² also at the behest of Maudsley psychiatrists. Temporarily resident foreigners have always been able to get treatment in Britain and hopefully always will. In the case of drug dependency, particular concern had been expressed by the government to prevent the spread of AIDS and avoid the sort of dreadful consequences now seen in American cities.³ In the case cited care was taken, including urine analysis, to establish the nature of the case and monitor the response.

Although methadone and diamorphine have similar pharmaceutical strengths, the effect of methadone lasts several times longer. Thus, in a tolerant subject daily doses of 80 mg methadone and 900 mg diamorphine are about equal. Incidentally, 900 mg is far less than the dose prescribed by earlier Maudsley psychiatrists to addicts when they did operate the British system. Their cases included daily doses of 1-2 g to Americans.⁴ But the real question is why do Strang and Farrell not use the doses of drugs allowed under the Dangerous Drugs Act 1920 and the Misuse of Drugs Act 1971?⁵ London might be a safer and healthier place with fewer addicts if they did.

JOHN MARKS

Chapel Street Clinic,
Widnes,
Merseyside WA8 7RE

- 1 Strang J, Farrell M. Drug regimens that break a country's drug laws. *BMJ* 1993;307:1010. (16 October.)
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No rationale for prescribing cocaine to addicts

EDITOR,—John Strang and Michael Farrell draw attention to the remarkable case of the cocaine commuter, an American citizen who regularly visited Britain to receive, from a doctor, a prescription for 900 mg heroin daily and an unspecified dose of cocaine.¹ In my view, this is not only a criticisable exercise of clinical freedom but is also unethical.

Treatments for drug dependence should broadly conform to national guidelines² and the generally accepted tenets of usual medical practice. The guidelines state that it is "undesirable to prescribe substitute stimulant drugs." There is no accepted rationale for prescribing stimulants such as cocaine. It should be remembered that in the 1960s cocaine was prescribed in large doses to some heroin addicts. This had disastrous results: a retired chief inspector of the Home Office Drugs Branch reported, "The heroin dose never came down and the cocaine went up."³ It is an ethical imperative that medical treatments should lead to some health gain by the patient.

There are several reasons why the apparently inadvisable treatment of one patient should arouse concern. Firstly, the profession has to respond to medical practice that amounts to a questionable use of clinical freedom and which may be unethical. Secondly, the national press has started to take an interest: on 19 September the *Sunday Times* reported that a clinic near Liverpool was prescribing crack cocaine and aired local concerns that other crack users would be attracted to that area to get similar treatment. Lastly, as Strang and Farrell point out publicity surrounding this issue may lead to a call for international harmonisation that could restrict our prescribing responses. If medical practitioners are neither influenced by their peers nor subject to self regulation then the profession's status becomes open to question.

ANDREW JOHNS

Division of Psychiatry of Addictive Behaviour,
St George's Hospital Medical School,
London SW17 0RE

- 1 Strang J, Farrell M. Drug regimens that break a country's drug laws. *BMJ* 1993;307:1010. (16 October.)
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Undergraduate medical education

Teaching deserves better recognition

EDITOR,—The problem with changes is that they occur at times of need when resources to implement them are scarce. This is true of the health care reforms and the Tomlinson rationalisations and is probably true of the General Medical Council's recommendations on undergraduate medical education.¹ To some it is perfectly reasonable to look to medical teachers, whose bread and butter it ought to be to translate the vision into reality. As

most academics know, however, teaching counts for little with regard to recognition and promotion. While teaching is often said to be taken into account in some vague way, there is little doubt that research achievements are what really count.

In 1984 the American Academy of Medical Colleges recognised that educational reforms were unlikely to advance unless the contribution of staff to medical education received appropriate recognition. Since then several American medical schools have established career tracks for educators.^{2,3} These schools have adopted the general principle of promoting staff who are of value to the institution whether in teaching, research, or administration. They generally lack the pyramidal structure of academic departments in British medical schools, where educators and research workers may compete for a small number of senior posts. Another factor is their willingness to capitalise on the strengths of their staff rather than to pick at their weaknesses.

A major objection to the promotion of staff on the basis of their contribution to medical education is that measurement of quality is a matter of judgment. This objection, which is equally true of research, has effectively been overcome by implementing detailed assessment procedures and publishing the results, which include records of achievement, evidence of scholarly activity, and extensive peer and student review.^{4,5} With such information, schools have been able to recruit and retain the staff they need to implement curricular reforms.

If any useful reform is to occur in Britain, medical schools will need to value and develop the educational expertise they already have. This will remain an unattractive option, however, if it diverts staff from maintaining research ratings. Nevertheless, medical schools primarily exist and are mainly funded for the education of students. Until this priority is accepted the General Medical Council's latest recommendations risk having as little impact as previous ones.

D MARK CHAPUT DE SAINTONGE

Department of Clinical Pharmacology
and Therapeutics,
London Hospital Medical College,
London E1 2AD

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Too many facts, not enough innovation

EDITOR,—Stella Lowry has acquiesced in the notion that British medical education may prosper through accelerated adoption of the "core and options" model.¹ There is nothing novel about the deceptive allure of a core curriculum, but those tempted by it should be aware of generic arguments against this particular solution² or of voices that counsel moderation in the definition of foundation medical knowledge.³ Warnings about the "restrictively fat core"⁴ and the elusiveness of defined objectives in core medical education⁵ have not yet been countered.

Implicit in the core and options approach is the acceptance of an illusory degree of homogeneity in medical education and practice. There is now consensus that a curriculum centred on facts will not serve well in the future: the cascade of biomedical knowledge is already overwhelming. Mastery of concepts and skills will probably