situation. The consumer is reasonably happy with it, it is politically acceptable, and it is probably more equitable. It does, however, mean that we must accept the inevitability of waiting lists as a method of rationing.

Well managed waiting lists, for all their problems, are a good method of rationing. They are explicit and can be regulated to ensure that they are equitable. Furthermore, they are reasonably acceptable to the public: far better to be on a waiting list than to be told that an operation on the NHS will never be done under any circumstances.

Our view is that economic dogma has held sway for too long in health care. Yet when the hard decisions are being made in health authorities and health boards the dogmatists are nowhere to be seen. We should now formalise the social model of resource allocation along lines that have been suggested previously.³ With this method economic appraisal is but one of the four variables—with government priorities, consumer opinion, and formal needs assessment—that determine resource allocation. We would thus ensure that the NHS was, as Smyth puts it, “an element of the national apparatus of justice.”

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Searching published reports

SIR,—Ray Jones states that authors ought to review published reports,¹ but this is not feasible when they are presenting results of original research in the usual 2000 word paper, and especially not in a short report in the *BMJ*. A review of publications requires a dedicated article.² With our 600 word short report our priority was to include important details of the method and results, thus allowing only a few brief references to other reports.³

In the domain of access to medical records the 31 papers that Jones cites as a large number seem to us to be remarkably few, given that there are 44 medical specialties⁴ and that these papers address such diverse questions as patients' anxiety, the number of records lost, and corrections to the records.¹

We stand by our assertion that with regard to patients' attitudes after they have seen their records no study before ours had systematically examined the influence of demographic data and diagnosis. The reference that Jones cites as counter to this deals with physicians' censoring of computer held records and takes no account of patients' attitudes.⁵ Furthermore, as all these patients were diabetic the effect of diagnosis could not be evaluated, and the demographic data are presented in a non-numerical manner with no evidence of statistical testing. When we wrote of systematically examining the influence of demographic data and diagnosis we had in mind controlling for confounding factors to evaluate the contribution of a specific variable.⁴

Jones has misunderstood our point about the difference between patients given their records without having asked for them and those who ask to see their records, as the reference he gives deals with the first group.⁵ We believe that the second constitutes a different and self selected population who may, for example, be aggrieved by their

medical treatment. As we pointed out, we are aware of only one study of such patients.⁶

Whether authors are prolific or sparing in their use of references depends on personal style, the journal, the length of the article, and the published reports. Studies with poor methodology may be ignored even by review articles. If Jones objects to our use of three references in a short report what about an editorial of about 4000 words in a recent issue of the *British Journal of Psychiatry*, which has only one?⁷

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SIR,—I am delighted to see R Jones opening the debate on the searching of published reports.¹ I would, however, like to correct the widely held notion that Medline is the only relevant bibliographic tool for clinicians. Although it is an excellent index, it has a European rival, Excerpta Medica, which is all too often overlooked. Medline is the cheaper and more accessible of the two but it has a pronounced North American slant. The overlap of journal titles indexed by the two databases is only 36%, and Excerpta Medica indexes far more European and Japanese literature than does Medline. A well structured Medline search will yield a good solid overview of the literature in most areas, but the results are far from comprehensive. Far better to search both databases and even then to acknowledge that one has only covered such published research as has been indexed by these two sources.

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Advance directives

SIR,—Tony Hope discusses the implications of the Patient Self Determination Act in the United States.¹ The distinction between full mental competence and incompetence is not always clear cut, as is probably assumed in the act. This is particularly relevant for patients with uraemia, for whom advance patient directives may not be appropriate.

A 63 year old woman with insulin dependent diabetes was referred for a renal opinion when she presented with advanced renal failure. She was adamant that dialysis would not be acceptable to her at any stage. Repeated advice by her doctors and the renal team led her to “give dialysis a try.” Six months later she was receiving continuous ambulatory peritoneal dialysis and did not regret the decision to accept treatment. Had she been denied dialysis because her initial advance directive was accepted as final she might have died without treatment being offered again. Uraemia is often associated with reversible mental impairment that can be corrected with dialysis.

Complacency on the part of health providers is

an inherent danger if laws similar to the American act are encouraged in Britain. A recent study from North America suggests that strictly following advance directives may not always be in a patient's best interest.² One hundred and fifty mentally competent patients receiving dialysis were asked how much leeway their doctors should have to override their advance directive regarding continuation of dialysis if they developed Alzheimer's disease. Subjects varied in their responses from “no leeway” (39%) to a “little to a lot of leeway” (30%) and “complete leeway” (31%). If 61% of mentally competent patients are willing to let their doctors decide whether treatment should be continued, where lies the justification for encouraging advance directives for treatment?

Perhaps in this instance the “American experiment” should be viewed with traditional British scepticism.

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Paediatrics in the Tropics

SIR,—In the review of the book *Paediatrics in the Tropics*, of which I am a coeditor, G J Ebrahim's final sentence is: “As it stands it is a comprehensive text of paediatric medicine.”¹ As this is what we set out to achieve we are grateful for this acknowledgment. The preceding statement in the review—that “readership has not been defined, which may partly explain why only a few of the problems get a proper airing”—is, however, mystifying as the purpose of the book and the readership are clearly set out in the preface (page xi) as follows:

Recent years have seen an outpouring of publications on primary health care, health economics, health system management, health education and so forth, targeted mainly at developing countries and directed toward community rather than individual needs. These publications are needed and welcomed but a hiatus has developed in books that meet the needs of clinicians, in particular those who meet the whole spectrum of disease in childhood, and who, within the resource constraints of their practice, aspire to share the benefits of modern medical science with their patients. This book attempts to fill that hiatus for doctors in tropical developing countries. It aims to be a helpful companion to those who tend sick, disabled and handicapped children and offers guidance on how to integrate such activity with disease prevention and health promotion in the communities they serve.

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- 1 Ebrahim GJ. More than medicine. *BMJ* 1992;304:325. (1 February.)

A patient's charter for laboratories

SIR,—M J Stewart has highlighted some non-analytical aspects of the service provided by laboratories in the form of a patient's charter.¹ Though we agree with the general spirit of this charter, there are some constraints that are unlikely to diminish, at least in the near future.

The suggestion that results of less common tests (which presumably include tests of thyroid function, protein electrophoresis, and measurement of concentrations of cortisol, gonadotrophins, and immunoglobulins, etc) should be available

within 48 hours, however desirable, would be difficult for most district general hospitals to comply with, even with the best will in the world. Most of these tests are usually done weekly to reduce costs and to fit in with the working of the laboratory. The same applies to results of tests that would be required in a clinic—for example, measurement of glycated haemoglobin and drug concentrations for therapeutic drug monitoring. The soaring costs would not impress our managers, however much it might improve the quality of the service provided.

Finally, it is interesting that Stewart refers to “properly staffed laboratories.” Perhaps the time has come for a national charter for laboratories prepared by professional bodies, which could include guidelines about staffing and budgetary requirements for laboratories serving a given population. This would help to ensure that the provision of pathology services was not totally dictated by market forces, with everything determined by a price label.

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Audit: the crucial role of medical records

SIR,—M G S Dunnill and S R Gould's retrospective audit of acute gastrointestinal bleeding in a district general hospital highlights one of the main obstructions to audit and attempts to improve outcome—namely, the medical record.¹ Drawing any satisfactory conclusion from medical audit is difficult when 44% (46/104) of the case notes are unavailable. This is not an isolated problem.² Patients' care is also handicapped when notes are unavailable in outpatient departments or on the wards.

Until this problem is resolved we will have to rely on prospective audits with data collection independent of case notes. Good, accessible medical records are the foundation for medical audit, clinical care, coding, resource management, and so on. They are fundamental to the service, and improvements are urgently needed.

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Audit in general practice

SIR,—In the past few weeks the medical journals and newspapers have exhorted general practitioners to audit 13 aspects of care—namely, the standards of diabetic care, hypertensive care, child health surveillance, and minor surgery; the care of patients who have hypothyroidism, have arthritis, have heart failure, or are receiving diuretics; the prescription of antibiotics and of non-steroidal anti-inflammatory drugs; the waiting time for an appointment and after the appointment time; and consultation techniques.

I have a list of 24 other aspects of medical care that apparently need to be audited by competent, keen general practitioners. For each of these a protocol needs to be established and standards set. The care given has to be measured, a plan for

improvement defined, and the care measured again after a defined time has elapsed. Audit is not a once for all activity. This process has to be repeated in a cyclical manner for each aspect of care audited.

In our practice we have done some audit. We have published our results. The minimum time it has taken us to collect the data has been two weeks, using our ancillary staff to the full.

My list of aspects of care that need to be audited is, I am sure, incomplete, but with the ones given above there are now 37 aspects of care on the list. How do you audit all of them? If you do not audit all of them how do you choose which to audit? I guess that most people audit aspects of care that they are interested in or happy with—not an ideal way to improve your service. If you audit only half of these 37 aspects of care how much extra time do you spend on this process and what do you give up in your normal working day to produce this time? Already I have less time than I would like to visit my terminally ill patients and to counsel patients with alcohol and drug related problems (my interest: perhaps I should audit this?) despite working a 12 hour day.

I submit that the undirected general call to practise audit is illogical and unworkable and leads to disillusionment. I suggest that jointly the General Medical Services Committee and Royal College of General Practitioners should define one aspect of practice each year, define protocols, and encourage doctors all over the United Kingdom to audit this aspect of care against the protocol. Who knows, the care might become better, the improvement might stick, and little by little general practice as a discipline might improve further.

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NHS distribution of funds unfair

SIR,—The idea that NHS resources should be allocated according to health need is generally accepted. The underlying objective of the Resource Allocation Working Party was to seek criteria that were broadly responsive to relative need.¹ *Working for Patients* proposed using a formula based on population weighted for age and morbidity for distributing funds to regions and suggested that district health authorities should be funded on broadly the same basis, taking local factors into account.² West Birmingham Health Authority, however, in a paper presented to its region, has claimed that the national formula gives too much emphasis to the size of districts' elderly populations.³ It argues that deprived districts tend to have fewer elderly people than more affluent districts. Consequently, the current national formula is biased against deprived districts.

To test this hypothesis we examined the relation between mortality (a proxy for deprivation) and the proportion of elderly people in a district population. Our source of data was the Department of Health's common dataset. We calculated the percentage of people aged 65 and over in 190 district health authorities in England, using 1990 mid-year population estimates. All cause, all age standardised mortality ratios, based on deaths for the five years 1986-90, were abstracted for the 190 districts. To investigate the relation between these two variables we calculated the product-moment correlation coefficient; it showed a highly significant inverse relation between the percentage of elderly people and standardised mortality ratio ($R = -0.32$ (confidence interval -0.45 to -0.19), $p < 0.0001$). A simple linear regression analysis (table) yielded the predicted standardised mortality ratios for a given percentage of elderly people. Districts with the highest percentage of elderly people can expect to have the lowest standardised mortality ratios. Because of the known geographical variation in standardised mortality ratio dis-

Predicted standardised mortality ratio for English districts according to percentage population aged over 65, derived from regression analysis

% Aged over 65	Standardised mortality ratio (confidence interval) for English districts (n=190)
12	106 (103 to 108)
13	104 (102 to 106)
14	103 (102 to 105)
15	102 (101 to 103)
16	101 (99 to 102)
17	99 (98 to 101)
18	98 (96 to 100)
19	97 (95 to 99)
20	96 (93 to 98)
21	95 (92 to 98)
22	93 (90 to 97)
23	92 (88 to 96)
24	91 (86 to 95)
25	90 (85 to 95)

Regression of standardised mortality ratio on age: slope = -1.225 (SE 0.26). t Test for $b = 0$: $t = -4.7$, $p < 0.0001$ (two tailed probability).

tricts were classified as north or south, and the regression analysis showed similar results for both groups.

This finding raises fundamental questions about the way in which age structure should be used to allocate resources. We contend that the most likely explanation for the low standardised mortality ratios in districts with a high percentage of elderly people is selective migration: those who cannot afford to move to affluent retirement areas are likely to be less healthy than those who can. Therefore there are health differentials between elderly populations: old people who live in district health authorities with the lowest percentage of elderly people probably have the greatest needs. It follows that a resource allocation formula that moves money away from younger populations to retirement areas will move resources away from deprived inner city areas.

In our view, the current national formula, if used at a district level, is likely to increase the health differential between affluent and deprived populations. The Department of Health and regional health authorities should take account of this when deciding whether age structure should affect the distribution of resources in the NHS.

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Europe and nutrition

SIR,—Michael O'Connor makes a plea for a food policy in the European Community that puts human health before farmers' profits.¹ He assumes that a healthy diet will prevent the “coronaries” from which his group takes its name. He ignores the facts.

Keys's seven countries study showed significant association between the proportion of dietary energy derived from saturated fatty acids and the 10 year coronary death rate.² When intake of saturated fatty acids is plotted against coronary death rate for 23 European countries (including five of Keys's seven), however, there is no significant relation,³ which makes a causal basis for Keys's unconfirmed statistical association unlikely.

More importantly, some of the most extensive