often inherently contradictory requirements of society and the rights of the individual—that “creates an ethical dilemma and tension which lead many prison doctors to adopt a passive attitude.”¹ Until the service becomes independent the risk of continued unethical practice will remain.

The white paper on the future of the prison service was published last year.⁴ It recognises that the prison medical service must move closer to the NHS, even purchasing services from the NHS or other providers, but reasserts that the medical service will remain part of the prison service. Yet independent medical services have been achieved: in parts of Switzerland prisoners' health care is solely the responsibility of the Swiss health service and prisoners receive the same quality of care as the general population.⁵

Richard Smith's proposal that district health authorities and family health services authorities should use their unrivalled experience to purchase health services for prisons along with those for the community is a practical solution to what has become an intractable problem, and it deserves serious consideration.⁶ The regional directors of public health are to be commended for their prompt expression of cautious interest and for the suggestion that pilot schemes should examine the feasibility of further integration.⁷ If the proposal could be made to work it could get us all off the hook.

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Finding younger, representative representatives

SIR,—Having been a member of the BMA divisional executive and of the representative body for many years, as well as having served on the local medical committee and conference of local medical committees, I am disturbed to discover how little interest there is in succeeding those of us who are now retiring. Perhaps it is different elsewhere, but after well advertised elections Hampshire Local Medical Committee has eight vacancies and Southampton District GP Committee has 11. The district committee in particular is relevant to the everyday work of general practitioners, interacting as it does with the district health authority and its units. It is a tragedy that the representative voice of general practitioners will be less influential in decisions regarding the provision of medical care locally.

Was I the only voter to be concerned about the dearth of young and middle aged, middle of the road candidates for election to the BMA council recently? I thought that an undue proportion of the candidates were retired from full time practice or in other ways untypical of working doctors, so that the resulting representatives will inevitably be unrepresentative.

The answer, of course, is for more average working doctors to take on representative duties locally with a few proceeding to regional and national representative duties, encouraged and

supported by local colleagues. Surely public spirit can yield a few representative representatives.

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Randomised clinical trials in general practice

SIR,—We are indebted to Viv Peto and Angela Coulter,¹ G Tognoni and colleagues,² and P L Jonker and C A Sumajow³ for airing the problem of general practitioners recruiting patients for research. We are about to embark on the “stopping treatment of selected hypertensives” (STOSH) trial and will heed their warnings. We plan to recruit 500 well controlled hypertensive patients from about 25 practices with a view to stopping their drugs while closely monitoring blood pressure over three years.

We approach the problem of general practitioner cooperation with guarded optimism and believe that we have good reason to expect closer cooperation than the above authors. We have been able to build in a number of important incentives which we think will be attractive to our colleagues: we are fellow general practitioners and, between us, have had previous contact with most practitioners; our trial can expect to decrease practice expenditure on drugs; we can show benefit to patients; we can expect to improve the quality of care of hypertension in participating practices; and we know that most of the training practices have experience of a multicentre research project.

The inverse law of research⁴ highlights the anomaly that research resources are least available where they are most needed—that is, in general practice. While the Department of Health continues to fund 600 full time research registrars in hospitals posts and none in general practice,⁵ much important research in primary care will be carried out by outsiders. When this imbalance is corrected,⁵ we believe that the patient recruitment problems will be solved.

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Audit in general practice

SIR,—I sympathise with Edwin Martin's despair at being overwhelmed by a tide of audit,¹ but it need not be so. As an audit facilitator who is in full time general practice, I advise colleagues to follow certain guidelines to make audit user friendly from the beginning. These are:

- (1) Don't overburden yourself by being too ambitious: failure demotivates.
- (2) Audit only one topic each quarter.
- (3) Meet once a month for a maximum of one hour.
- (4) Limit your standards or criteria to a few (for example, three to six) of the important aspects of the topic; leave the others to a future audit.
- (5) This point is important: in auditing a clinical condition don't attempt to review every case in the practice. Look at the records of, say, 10 patients

per doctor, chosen at random. This takes less than two minutes for each record—no more than 20 minutes per doctor—and will easily be sufficient to show where care can be improved. You are not looking for statistical significance, merely for evidence sufficient to convince you that change is necessary.

(6) Discuss the findings and any shortcomings at the next audit meeting, agree on the standards that you will try to keep to until the audit is repeated, and record your decisions in writing.

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Fundholding general practices

SIR,—Angela Coulter's editorial on fundholding general practices is generally accurate and fair,¹ but as a first wave fundholder I disagree with three contentions.

Firstly, it is untrue to say that past activity was difficult to determine. During 18 months of preparation for fundholding my practice compiled comprehensive data, using manual systems, on inpatient and outpatient referral patterns and use of pathology and x ray services. Our budget was negotiated on the basis of these data. Analysis of our activity during the first eight months of fundholding showed that our inpatient referrals were within three of the predicted level, and we are on course to spend 99% of our total budget.

Secondly, fundholding does not provide any incentive for practices to remove from their lists or refuse to register expensive patients. We maintain a list of expensive patients (such as those receiving growth hormone, in vitro fertilisation, and goserelin) and have used data on them in negotiating our drug budget.

Thirdly, concern about the setting up of private companies is a separate issue from the provision of physiotherapy by fundholders. Before April last year the waiting time for physiotherapy in Hemel Hempstead was never less than 12 weeks, was a clear indication of unmet need, and caused many acute conditions to become chronic. My practice does not yet have a limited company, but we have purchased and provided both in house physiotherapy and access to a local physiotherapy clinic. Our referrals have increased, our patients can be seen and assessed within days, and we have reduced the load on the local hospital. These arrangements illustrate both increased activity and benefits to the whole local community resulting from fundholding.

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Appointments committees for vocational trainees

SIR,—Nick Evans's plea for a change in the system of appointing consultants¹ has been supported in recent correspondence.^{2,3} For some years we have recognised similar problems in the appointment of trainees to vocational training schemes for general practice.

The size and lack of structure of the interviewing panel, combined with the intimidation that the trainees felt, led us to reappraise our interviewing skills. This was reinforced by experience from outside the health service (gained from appointing a head teacher of a primary school) and the