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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- 1 Martin E. Audit in general practice. *BMJ* 1992;304:643. (7 March.)

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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- 1 Coulter A. Fundholding general practices. *BMJ* 1992;304:397-8. (15 February.)

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

comments of the Joint Committee for Postgraduate Training in General Practice in its report for Dudley and Sandwell, which highlighted this as a potential difficulty.

We organised a weekend course for all the trainers to learn how to interview, with an appreciable input from non-medical people. It became clear that our interviewing skills were poor, and as a result we rethought the whole way of interviewing potential trainees. Rodger wrote the seminal work on this subject in 1952,⁴ and it has been reiterated by others more recently.^{5,6}

As a result, we have reduced our interviewing panel from 12-18 to four—two consultants and two general practice trainers—with a neutral chairman. This is a much less intimidating ordeal, but the questioning is no less probing for this change. The reduction of interviewers means that those involved in the training scheme but not invited to interview candidates have to trust the panel.

We believe that this change has considerably improved the interviewing procedure. It has already worked well in the Dudley scheme, and we strongly recommend it to other interviewing panels. We must recognise that we have a lot to learn from non-medical experts when it comes to interviewing procedure.

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- 1 Evans N. There must be a better way. *BMJ* 1991;303:1483. (7 December.)
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allowed to stand in the way. If money is needed and central government will not release extra funds then managers must make economies elsewhere—even, as a last resort, to the extent of cutting back on patient services. Improving juniors' hours should of itself lead to improvement in the quality of care but perhaps for fewer patients.

It is regrettable that Miles Irving confines himself to deprecating the juniors' consideration of industrial action on the grounds that "strikes are not an option available to those who have the privilege of looking after patients."⁶ But what if, yet again, the initiative runs into the sand? His sanctimonious stand against industrial action leaves juniors with no ultimate bargaining power should it be needed. A cynical management, unless it believed that the juniors' armoury included industrial action, could be quite willing to continue running a sweatshop if to do otherwise would reduce income. After all, any management must try to produce more product for less money, and staff pay is often the biggest single cost.

Irving's letter, as published, includes no sympathy for the juniors' problems. It is time that he, and all seniors, took up the juniors' cause vigorously. This could break the deadlock speedily and without the need for industrial action. Unfortunately, any solution will probably require seniors to make major alterations to their own working practices. Sadly, I suspect that this will be too much of a culture shock for some of them.

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Junior doctors on the warpath

SIR,—Predictably to a retired consultant like me, the threat of industrial action by junior staff over their perception of the slow rate of progress in reducing their working hours has produced a few howls of righteous indignation. A P J Ross records that Wessex has made considerable progress with the problem in the past year.¹ Well done, but might I ask why it has taken so long when there has been managerial pressure for change for 10 years? Trent pats itself on the back for having made a good start—10 years too late.^{2,3} It would be better had the region waited until it could report actual achievement. But there are other aspects of Trent's response that sound loud warning bells.

R Alderslade and D R Cullen talk about available resources.² Resources are even scarcer now than 10 years ago. Is this preparation for the excuse that "We support the concept but we can't afford the change"? Do they seriously think that a lack of resources justifies the continuation of working hours which even a factory worker in the Third World would complain of? They also refer to "safeguarding the standards and safety of medicine" and "training and educational opportunities of our junior doctors." Do they really believe that either of these objectives is achieved by working some juniors to a state of mental exhaustion by ridiculous hours? Even the target of 83 hours a week amounts to nearly 12 hours a day, seven days a week.

Other letters have drawn attention to unsatisfactory aspects of the juniors' lot.^{4,5} The problem of juniors' hours has been with us for many years, and this time it must be solved. Resources cannot be

How journals identify their contents

SIR,—It is Friday, 5 pm: a reader rushes in, clutching a photocopy and asking, "Do you have this?" "This" refers to a paper by Biggles on axolotls. Computer magic identifies Biggles A, Bond J. Axolotls: a holistic approach. *Axolotology* 1989;130(6):599-607 (available in the library). Journals are kept in the familiar cardboard half boxes (remember the days of systematic binding?), and the following occurs: either the visible (upper) part of the spine shows the title, year, and volume and issue numbers as well as pages (first and last) in the issue—all is well; or the spine is insufficiently informative or limits information to its (boxed) lower part, which entails hauling out individual issues to look at the cover.

Mould recently discussed standardisation of journal covers.¹ The information given, and its position, on the spine and on pages is also relevant to the physical and mental health of library users. A multidisciplinary team (one librarian, one reader) examined the latest available issue for a random sample of 84 health related journals in 18 languages from 33 developing and developed countries in the headquarters library of the World Health Organisation in Geneva. The table summarises the results. Of the 38 journals that provided no relevant information whatsoever on the spine, 16 were of more than 64 pages (the *BMJ*, not included in the sample, falls in this category); conversely, four journals with under 64 pages conveyed some information. Thus the size of the issue is not a major consideration. In half the

Availability of information on spine, cover, and inside page of article (not first page) of 84 journals

	Spine	Cover page	Inside page of article
None	38	2	18
Journal title	43	81	44
Year of publication	36	79	41
Volume number	39	72	41
Issue number	37	75	41
First and last pages	17	21	3

Fifty eight journals were of ≥ 64 pages.

remaining 46 cases information appeared on the upper half of the spine. In the other 23 cases information on the upper part of the spine was insufficient to identify an issue. One journal had recently "improved" its presentation from a fully informative spine to one that bore no information whatsoever; another provided extensive information on the bottom third of the spine.

On inside pages (excluding the first page of an article) no bibliographical information appeared for 18 journals. Twenty one journals had identical, incomplete information on every page; 18 others had incomplete information. For two of those giving incomplete information on any one page, combined items on two facing pages provided sufficient, albeit imperfect, bibliographical data. In only three cases was it possible to obtain full bibliographical information from every page. In 13 cases even the first page of an article did not systematically provide the name of the journal, and this page included full bibliographical information in only 22 cases.

Our findings highlight a lack of imagination among editors and publishers. Remedial action should ensure that journal spines bear at least the name of the journal, year, volume and issue numbers, and first and last pages of the issue on the upper portion of the spine and that each page carries at least the journal title and year or volume number. Including on each page the author(s), abbreviated article title, and first and last pages of the article would be advisable.

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Publishing papers from Germany in the *BMJ*

SIR,—Minerva states that the *BMJ* receives fewer papers from Germany than from Scandinavia and draws conclusions on the quality of clinical research not only in Germany but also elsewhere.¹ Minerva should have ascertained that there are 300 or so medical journals in Germany plus some others published in German in Switzerland and Austria. So the *BMJ*, notwithstanding its quality, is not the first choice of a German scientific author who wishes to have a paper published.

Basic medical research in Germany is concentrated very much in the universities, their standards of research being probably higher than their standards of teaching students. The international citation index of our researchers may be comparatively low—whatever in the rest of the world is willing to read the "awful German language" (Mark Twain)?—but this fate we share with the French, the Italians, and many other researching nations.

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- 1 Minerva. *BMJ* 1992;304:516. (22 February.)