Proportion of general practitioners indicating their wish for information in discharge letters concerning various aspects of their patients' attendance at accident and emergency departments

Aspect of attendance	No (%) of practitioners requiring information on aspect (n=213)
Mode of referral	194 (91)
General practitioner diagnosis (prior to referral)	134 (63)
Clinical findings in accident and emergency*:	
All positive findings	115 (54)
All negative findings	57 (27)
Only relevant findings	109 (51)
Results of investigations in accident and emergency:	
Haematology	187 (88)
Biochemistry	183 (86)
x Ray	191 (90)
Diagnosis in accident and emergency	208 (98)
Treatment in accident and emergency	202 (95)
Outcome (admit or discharge)	203 (95)
Treatment suggested for general practitioner	192 (90)
Follow up arrangements	200 (94)
Information given to patient	175 (82)
Information to general practitioner**:	
On all patients	160 (75)
Only those sent home	53 (25)

*Actual question: Would you like to know all positive findings? all negative findings? only "relevant" findings? other (please specify)? Some respondents replied to more than one category.
**Actual question: Would you like this information for all patients? for only those sent home? for only those admitted?

identify what information is essential, what is helpful, and what is thought to be less helpful. These circumstances are reflected in the findings of our survey (table), which differ somewhat from those of Newton and colleagues. Of the 400 general practitioners circulated, 213 replied (55% response rate). Over 90% of the respondents wanted to know what investigations had been performed in the accident and emergency department, what diagnoses were made, and what treatment was given. In addition, however, 80% or more of the general practitioners who responded wanted to know what follow up arrangements were made; what the patient had been told; what the practitioner was supposed to do; and how the patient came to be in the accident and emergency department in the first place. Most general practitioners were interested only in positive findings, and few felt that negative findings were relevant.

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1 Newton J, Eccles M, Hutchinson A. Communication between general practitioners and consultants: what should their letters contain? *BMJ* 1992;304:821-4. (28 March.)

Management training for senior registrars

SIR,—E M Gadd and M F Fletcher suggest that senior registrars are inadequately trained in theoretical and practical management.¹ This problem has been addressed in Wales, where each senior registrar is expected to attend two one week courses to develop these skills. We surveyed the 21 senior registrars who completed the most recent course and found that, although they all thought that the course was valuable, 18 were dissatisfied with their theoretical management skills and 16 with their practical management skills. The main problems were the lack of in service training and of experience. Practical management experience was largely limited to routine organisational tasks (devising duty and teaching rotas and running departmental and audit meetings). Few (six) had any formal contact with management,

and only five had attended meetings relevant to budgetary planning. In contrast to Gadd and Fletcher's study, only one of the senior registrars had attended a meeting at district level. Management training courses are important to senior registrars, but we should be given the opportunity to develop our management skills in hospitals before we become consultants.

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1 Gadd EM, Fletcher FM. Do senior registrars have adequate management training? *BMJ* 1992;304:546-7. (29 February.)

The supraregional assay service

SIR,—The NHS reforms associated with the provision of the supraregional assay services came into effect this month, bringing the prospect of a more fragmented, less cohesive, less cost effective, and considerably more expensive service, not to mention the masses of associated paperwork.¹ Worse still is that the money required by the individual laboratories to pay for these services has not been clearly identified in all cases. As a result, what used to be funded centrally will now have to come locally from existing laboratory budgets (at least for this year). This is not unlike the problems that many laboratories are facing with the changes in funding for national external quality assessment schemes, which also came into operation this month. Money supposedly top sliced at regional level for allocation to this scheme has failed to trickle down to individual units in most cases. Once again, it will have to come from local funds (that is, laboratory budgets), and I can only hope that regional money will eventually find its way to individual laboratories.

Are all these examples just underfunding by a different name—reform? Yet this is just the beginning of the reforms, and we can expect more of the same in other areas of the NHS. Could someone please enlighten us as to the benefits to the patient or the clinician, or indeed even individual laboratories, in all these changes?

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1 Lester E. The supraregional assay service. *BMJ* 1992;304:790-1. (28 March.)

SIR,—I have beside me a file, which was once slim and concise but is now bulging with a plethora of documents from each of the laboratories in the supraregional assay service, comprising letters of intent, tentative and definitive price lists, "advertising" leaflets, and so on. Disturbingly, one such letter demands that payment must accompany each sample sent. Should I continue to use these services the administrative time required to process the extra paperwork will add considerably to the overall cost (a situation presumably duplicated throughout Britain)—as Eva Lester forecasts in her editorial.¹

Accordingly, I have examined the in house costs of all but the most esoteric or technically complex assays and have concluded that many tests done by the supraregional assay service could be adequately handled locally, thus benefiting my budget. Mine, however, is a "bread and butter" laboratory, and though we are competent enough both technically and in interpretation, our skill will of necessity be diluted by the needs of other aspects of the service and will be inferior to that of the specialist

laboratories. Nevertheless, managerial pressure to introduce cost savings is strong and may well overcome such professional misgivings. If other heads of department follow the same reasoning laboratories in the supraregional assay service, with all their skill, research, and training facilities, will be in jeopardy. As a consequence a short term financial gain for individual departments will risk the destruction of a valuable asset to the NHS. The ultimate loser will be the patient.

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1 Lester E. The supraregional assay service. *BMJ* 1992;304:790-1. (28 March.)

Seat belts in pregnancy

SIR,—Deborah Moncrieff and Jayne Cockburn's letter¹ seeks to modify the advice given in my editorial on the use of seat belts in pregnancy.² The three point harness dissipates crash energy through the skeleton. The addition of a small cushion under the lap strap is therefore positively dangerous as not only is it likely to slip during the accident but by holding the belt away from the skeleton it defeats the purpose of the restraint. This is likely to lead to an increase in soft tissue injuries of the pelvic organs. If the belt rides up to lie over the symphysis it will still effectively act through the skeleton. The woman who still needs to travel by car in late pregnancy should therefore be advised to put up with the discomfort and to reduce the journeys to the absolute minimum.

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1 Moncrieff D, Cockburn J. Seat belts in pregnancy. *BMJ* 1992;304:986. (11 April.)
2 Pearce M. Seat belts in pregnancy. *BMJ* 1992;304:586-7. (7 March.)

Hype in the BMJ

SIR,—One of the ordeals facing a doctor involved as a defendant in litigation is that of publicity. Having been recently involved thus, I found that in press reporting it is the headline which, as well as being the most eye catching, is liable to the most inaccuracy.

The brief national press coverage of the case was restrained and responsible in its headlining, so I was extremely perturbed to see that the headline in the news section of the *BMJ*¹ indulged in the journalistic hype, referred to in Richard Smith's editorial,² characterised by the sensational "excesses of Sunday's papers." Clare Dyer makes it clear that the case was complex and required some five days' argument in the High Court between medical experts.

In the event the issue was settled out of court, undebated and without judgment. Despite this the headline, "Chilblain medicine gives woman brain damage," is uncompromising. If the causal relation is unproved it should not be stated as fact—not in a journal that surely takes pride in scientific accuracy.

I believe that the headline has, on this occasion, let down both legal and journalistic professions in that it was misleading, judgmental, and hostage to sensationalism.

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1 Dyer C. Chilblain medicine gives woman brain damage. *BMJ* 1992;304:799. (28 March.)
2 Smith R. Hype from journalists and scientists. *BMJ* 1992;304:730. (21 March.)