pean Community in particular. There would then have to be a considerable increase in career registrars and senior registrars, which would negate the intention of *Achieving a Balance* just as it was beginning to become really effective, or there would be many senior house officers in the system with no prospects of promotion.

The staff grade and other non-training grades are not the answer: they cannot be expected to solve the on call commitment in any appreciable way as the number of such posts is limited to a maximum of 10% of the consultant establishment. The alternative is for an increase in consultant numbers without a commensurate increase in junior staff and for a change in consultants' working practice. In many disciplines consultants would have to work in larger teams and accept being on call, often with only one level of cover. They would be involved in much more day to day care. This message has not yet been made clear to the consultant body, but I suggest that this is the only way in which the aims of both the agreement on junior doctors' hours and *Achieving a Balance* can be reconciled.

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1 Carney A. Patterns of hospital medical staffing. *BMJ* 1992;304:1197-8. (9 May.)

EDITOR,—Andrew Carney's article on patterns of hospital medical staffing does not address the main problem—namely, the lack of a career grade equivalent to the army rank of major.¹ *Achieving a Balance* has always been unrealistic—demonstrably so in the light of the recent heads of agreement and the new restrictions on juniors' working hours.

The medical career structure in hospitals suffers from several main defects, among which are that everyone has to reach the top; that clinical responsibility is equated with the top grade; a failure to accept at junior level the need for both career and training posts, to the detriment of both; the false concept of a fully trained, rather than adequately competent doctor; and that a consultant's job has too many facets, with inevitable professional and geographical conflicts.

In the services the bottom three ranks are roughly equivalent to preregistration house officer, senior house officer, and registrar (including senior registrar). Once initial regimental training is complete officers spend periods at these levels in regimental work and training work—for example, attending staff college courses. All are guaranteed promotion to regimental officer at field rank; at this rank they are fully professionally competent but are able to take advice from above. The competent move upwards to the general ranks and the less competent sideways to less taxing jobs. In the health service there is no career grade that everyone must achieve, and through which everyone must go, but is not the top. Promotion from senior registrar to consultant is the equivalent of promotion direct from captain to general. Until there is an equivalent to field officer in the health service the career structure will inevitably result in overwork for junior staff and violent fluctuations in supply of, and demand for, consultants.

A middle buffer to smoothe these problems out is essential for a successful career structure. On promotion to this specialist grade doctors would be competent specialists with clinical responsibility but able to take advice from consultants in the same way that general practitioners do. Those good enough would be promoted to do true consultant work, while the less competent would move sideways to do less taxing, but nevertheless essential, sessional work. This would give those responsible for acute emergencies and the very ill, including the new specialists, time to concentrate

on this work with some relief of the routine workload. Consultants would contribute to clinical medicine, management, research, and national advisory machinery, for which they would be paid, and would tend to specialise more in one type of work than at present.

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Racial discrimination in registrar appointments

EDITOR,—The proposed investigation by the Commission for Racial Equality into alleged discrimination against ethnic minorities in the appointment of consultants, though most welcome, is not likely to come up with the full facts.¹ Consultants can be appointed only from candidates who have risen through the system to the senior registrar cadre. The chance of doctors from ethnic minorities achieving this is hampered by their inability to get a good registrar post. It is generally known that many otherwise well qualified senior house officers are unlikely to be short listed for registrar jobs simply because their names are easily recognised as foreign.

The restrictive system of appointment to registrar posts that have future prospects—previously based on unwritten understanding—is now becoming official policy with the categorisation of jobs into career and visiting posts, as proposed in *Achieving a Balance*. The real intention of this is to exclude all foreign competition. A few doctors from ethnic minorities are now being caught in the no man's land of being unable to apply for either visiting registrar jobs (because they have full residency status) or career registrar jobs (because their names do not sound right).

The average doctor from an ethnic minority asks to be allowed to compete where meritocracy is the norm. If the Commission for Racial Equality cannot do something for him or her at registrar level neither can it do anything at consultant level.

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1 Beecham L. Are doctors from ethnic minorities discriminated against? *BMJ* 1992;304:1513. (6 June.)

Neonatal intensive care and the NHS reforms

EDITOR,—Information on the effects of the NHS reforms on neonatal intensive care was sought by a questionnaire sent out last March, at the end of the first full year of the changes. The questionnaire was sent to named neonatologists working in 50 British neonatal units, including all the recognised regional and subregional units in every health region in England and Wales as well as Scotland and Northern Ireland.

Forms were returned from 33 neonatal intensive care units, which tended to represent the larger units. The median (range) number of infants mechanically ventilated in these units was 116 (18-200) a year. Thirteen units were part of hospitals that had become trusts in either the first or the second wave. Ten respondents reported that their unit had received an increase in its recurrent budget in the financial year 1991-2, and six of these were in trust hospitals. Only three units reported a reduction in their recurrent budget, and all were in non-trust hospitals. Nine units reported that they had admitted "significantly more" babies to their unit for intensive care in the current year compared

with the previous year; only two reported having admitted "significantly fewer." Five of the units that had admitted more babies were in hospitals that had no plans to become trusts, and one of those that had admitted fewer babies was in a hospital intending to become a trust.

Replies were obtained from at least one unit in each of the 14 English health regions as well as Wales, Scotland, and Northern Ireland. Responses indicated that there was a regional plan or strategy for perinatal services in each of the 17 regions, but six indicated that there seemed to be a fading or absent financial commitment to the plan. Only three regions seemed to be considering proposals for regional contracting of neonatal intensive care.

All respondents expressed a view on the effects of the NHS reforms on their units. Nineteen thought that there had been no change in their service, and seven stated that there had been an improvement and seven a deterioration. The commonest reason given for a worsening of the service was the perception that the regional structure of neonatal services was falling apart.

Despite the evidence for more babies being offered intensive care in the units sampled, there are few data to suggest that this is due to the NHS reforms; indeed, most of the units that admitted significantly more babies were in institutions that had not expressed an interest in becoming trust hospitals. The main concern of the consultants was the possibility of individual units "going it alone" and reducing the drive towards strategic planning of services on a regional basis. This is a particular fear in London.

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Checking quality of health care records

EDITOR,—C P J Charlton and C J Cuninghame express concern¹ about the accuracy and completeness of computer based immunisation records in Grampian.² We have addressed this issue before and are continually reviewing the quality of our immunisation records.^{3,4}

Immunisation data are held on the same computer as general practitioner registration data from which target payments are made, based on exactly the same denominator. This circumvents the problem reported by Jammi Nagaray Rao whereby general practitioners have to notify both the family health services authority and child health computers.⁵ At the time the data are entered the patient's details are checked by the computer against registration data, age at immunisation is validated for the accepted range of giving times, and vaccine data—manufacturer, batch number, and expiry dates—are compared. When discrepancies occur these are investigated and corrected by primary care staff. Grampian has a relatively stable population, and the proportion of children not registered with general practitioners is extremely small. We also, however, monitor all health visitors' immunisation records of children newly transferred into the area, cross checking with general practice sources.

The main method of data quality assurance is by quarterly feedback of immunisation figures to general practitioners, who receive target payments on the basis of the accuracy of these data. General practitioners and staff cooperate, using the information as a prompt for immunisations not yet performed and for correcting inaccuracies. Because of the continuous nature of this feedback discrepancies are minimised, and we have no reason to believe that the level of any residual error has changed throughout our study.²

Charlton and Cuninghame propose regular standard quality checks on computer health records, but this should be cost effective. We fear that the authors underestimate the effort and resources required in manual checking.³ In the future, electronic reconciliation of data on patients held on different computers must be pursued.⁴ In the meantime, we suggest that regular feedback of data to general practitioners is likely to improve accuracy and to encourage a higher rate of immunisation in the target population—the prime objective. Finally, we agree that computers, like humans, should be immunised against attack by viruses.⁵

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- 1 Charlton CPJ, Cuninghame CJ. Checking quality of health care records. *BMJ* 1992;304:1248. (9 May.)
- 2 Ritchie LD, Bisset AF, Russell D, Leslie V, Thomson I. Primary and preschool immunisation in Grampian: progress and the 1990 contract. *BMJ* 1992;304:816-9. (28 March.)
- 3 Bisset AF, Thomson I. Use of computerised records to ensure optimum measles vaccination. *Health Bull* 1990;48:294-8.
- 4 Ritchie LD. Pertussis immunisation in Grampian. *BMJ* 1991;302:1208-9.
- 5 Rao JN. Data on vaccine uptake should be checked. *BMJ* 1992;304:1115. (25 April.)
- 6 Ritchie LD, Watt AH, Taylor MW. Large computer databases in general practice. *BMJ* 1991;302:1081.
- 7 Ritchie LD, Taylor MW, Milne R, Duncan R. Computer virus infection. *Lancet* 1991;338:1598.

Giving more information about drug treatment

EDITOR,—C F George raises interesting issues in his editorial on adverse drug reactions and secrecy.¹ Recent publicity about deaths due to high dosages of neuroleptic drugs widens the debate.² Members of the public have their opinion of drug treatment moulded by the information available. Obviously if this is adverse then convincing people that the risk:benefit ratio is acceptable becomes harder.

A survey carried out in a psychiatric day unit and ward showed that most people were dissatisfied with the information given about drug treatment.³ Leaflets giving general information and specific information about particular drugs were piloted. Patients considered that the written information improved their sense of satisfaction and provided extra information about side effects, which often caused concern. But the patients considered increased verbal communication with the prescriber to be important and thought that the leaflets should help patients to interact more meaningfully with the prescriber. Increasing the information available to patients in a responsible manner—that is, being available to answer queries arising from the written material provided—should enhance patients' confidence and compliance. Patients have shown that leaflets need to be in a language that they can understand.⁴

Professionals—for example, doctors and pharmacists—may need to provide leaflets in addition to package inserts to answer patients' queries in a manner to which the patients can relate. The complementary effect of information leaflets and discussion has been shown.⁵ Professionals need to consult patient groups extensively to establish matters of concern and attempt to clarify some of the issues regarding drug treatment through leaflets and enhanced communication.

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- 1 George CF. Adverse drug reactions and secrecy. *BMJ* 1992;304:1328. (23 May.)
- 2 Kingman S. Deaths fuel calls for more scrutiny of tranquillisers. *Independent* 1992 May 26:7.
- 3 Schnieden V, Mealham P, Greenberg M. Audit and action in

relation to drug prescribing for psychiatric patients. *Bulletin of the Royal College of Psychiatrists* 1991;15:85-6.

- 4 Servizio di Informazione e di Educazione Sanitaria, Farmacie Comunali Italiane. What information for the patient? Large scale pilot study on experimental package inserts giving information on prescribed and over the counter drugs. *BMJ* 1991;301:1261-5.
- 5 Regner MJ, Hermann F, Douglas Reid L. Effectiveness of a printed leaflet for enabling patients to use digoxin side effect information. *Drug Intelligence and Clinical Pharmacy* 1987;21:200-4.

Doctors and managers

EDITOR,—Trisha Greenhalgh takes me to task¹ for having implied that good management will not improve waiting times in outpatient departments.² This is far from what I intended to imply. Rather, by juxtaposing an account of a not untypical morning's clinic and a callous and unthinking remark by a senior manager I wished to show how bad management may contribute to lowering professional morale.

I have consistently advocated good management in the NHS ever since, as a senior house officer, I shared my on call duties with a trainee manager who had been seconded to the mess. I have defended the need for good quality management in the public press. But, as has been eloquently pointed out recently, good managers require some understanding of the business they manage.³ Such people exist, and they deserve the respect of their colleagues in the NHS. Others—troubleshooters brought in from often rather unsuccessful business enterprises—need to earn that respect.

As someone who, while trying to be a good (honorary) consultant, spent 13 years as director of a threatened but ultimately successful research enterprise, I have some practical experience of the problems of management. I understand the concept of "total quality" management but prefer the adjective "good." How far such good management, given no overall increase in resources, can make the NHS more cost effective remains to be seen. I dispute the contention that the NHS is a bureaucratic dinosaur: the opportunities I have had to work and study in other countries have given me considerable respect for the way it operates. Indeed, the hallmark of the recent reforms has been an enormous increase in bureaucracy, leading to much stress related illness in managers and others. If good management of the NHS saves money at the bottom—by reducing the hourly rates of cleaners, for example—that same good management should also identify and deal with the superefficiencies such as exploitation of junior doctors. The cost of the latter may well outweigh the savings from the former.

I argue that the greatest need for good quality management in the NHS is to save the service from the most damaging effects of this attempt to turn health care into a market commodity. To this end we should give our managers all the help we can.

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- 1 Greenhalgh T. Doctors and managers—time to end the cold war? *BMJ* 1992;304:1184. (2 May.)
- 2 Seaton A. Patients first—I wonder. *BMJ* 1991;302:1474.
- 3 Medicine: a complete and generous education? [Editorial.] *Proceedings of the Royal College of Physicians of Edinburgh* 1992;22:153-7.

Public attitudes to smoking in Avon

EDITOR,—We recently repeated a survey of public attitudes to smoking in Avon, using the same methods and questions as were used in a survey conducted in Avon in 1989.¹ On 23 April this year the practice receptionists at three health centres in

Avon invited all those attending to complete an anonymous questionnaire. The patients were asked to indicate whether they agreed or disagreed with several statements covering a range of issues relating to tobacco. Altogether 308 replies were received.

In 1989, 678 (71%) of the 951 people surveyed and 160 (58%) of the 275 smokers supported a ban on tobacco advertising, whereas currently 234 (76%) of the 308 respondents and 42 (68%) of the 62 smokers support a ban; the differences between these results are not significant. Generally, there has been a consistent increase in the number of both smokers and non-smokers who believe that advertising makes cigarette smoking more acceptable and that fewer young people would start to smoke if cigarettes were not advertised anywhere.

Since 1989 support for restrictions on smoking in the workplace and for the rights of non-smokers in the workplace has increased significantly. In 1989, 590 (62%) of the 951 respondents and 93 (34%) of the 275 smokers agreed that smoking should be banned to protect the rights of those who do not smoke; this year the figures were 224 (73%) of 308 and 29 (47%) of 62 respectively ($p=0.008$ and $p=0.076$ respectively (with Yates's correction)).

This survey suggests that over the past three years in Avon public attitudes among both smokers and non-smokers have hardened in favour of restrictions on smoking in the workplace and on banning tobacco advertising. The government seems to be increasingly out of step with public opinion on the issue of a ban on tobacco advertising, as Adrian Vickers points out in his editorial.²

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- 1 Bolger PG, Stewart-Brown SL. Public attitudes to smoking in Avon. *Health Education Journal* 1990;49:97-100.
- 2 Vickers A. Why cigarette advertising should be banned. *BMJ* 1992;304:1195-6. (9 May.)

Budget holding in Calverton

EDITOR,—As director of dermatology at Queen's Medical Centre in Nottingham, I wish to reply to John Bain's article about the budget holding practice in Calverton.¹ Until the development of fundholding the practice received considerable dermatological services from this department. It is not surprising that in the first year the cost per case for patients with dermatological problems seen for the practice was lower than that for patients sent to the dermatology department.

Firstly, the fundholding general practitioners' estimate of the work that they would have sent to the skin department in their first contracting year was more than they actually sent in total to any dermatological consultant; thus the money withdrawn from the dermatology directorate and its base hospital was out of proportion to the actual work that was "on offer" from the practice. In addition, of course, the more complicated cases were sent to Queen's Medical Centre, and this is borne out by the ratio of new patients to recalls, which was 6:1 for their practice, whereas the estimate for the current year (1992-3) is about 2:1.

Though we accept that simple dermatological consultations can be performed in general practice, the Calverton practice has to recognise that its contract for skin care has not been negotiated on a cost per case basis and that the price of the specialised hospital services is being subsidised by the major purchaser, Nottingham Health Authority, and therefore, indirectly, by non-fundholding general practitioner colleagues. If there