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

LEWIS D RITCHIE JOYCE MCADIE
ANN F BISSET IRENE THOMSON
VALERIE LESLIE

Grampian Health Board,
Aberdeen AB9 8QP

- 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.

VIVIENNE SCHNIEDEN

Huntley Centre,
London WC1E 6AU

- 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.

ANTHONY SEATON

Environmental and Occupational Medicine,
Aberdeen University Medical School,
Aberdeen AB9 2ZD

- 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

SELENA GRAY

Bristol and District Health Authority,
Bristol BS1 3NP

CHRISTINE HINE

Bath Health Authority,
Bath BA1 3QE

- 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