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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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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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.)
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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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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

had been a true estimate based on cost per case I doubt whether the Calverton practice would have maintained its optimism about dividing the services for specialised dermatological care. Bain has been careful to stay out of the discussion of the inevitable consequences when many general practitioners become fundholders. The cost of specialised services such as ours will rise enormously because the overall price is not diluted by the cheaper procedures and consultations. Indeed, in general, dermatology departments may be able to offer only certain specialised services and the patients locally will be the losers because they may need to travel some distance to find those specialised services not offered by their local large unit.

I applaud specialty consultation clinics in general practitioners' surgeries if they are safe, feasible, and not subjected to business wrangling, which threatens to destroy professional relationships between hospitals and general practitioners. This facility, however, must be offered to all general practitioners and their patients equally—for example, through the major purchaser such as the district health authority. There is no place for maintaining a two tier system which drains NHS money into private pockets, subsidises fundholders at the expense of other general practitioners, and offers short term financial gains to fundholders at the expense of maintaining a full and comprehensive local specialised facility for all local patients and their general practitioners.

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Ethics and multicentre research projects

EDITOR,—We support P C E Moodie and T Marshall's findings that the Department of Health's guidelines for local research ethics committees are inadequate.¹ They fail to give clear guidance for multicentre research studies, and we are concerned that they make no distinction between population based research and clinical studies.

We recently completed a population study for which we had to obtain the approval of 28 ethics committees. We identified three types of avoidable delay despite having a detailed protocol and letter. These were delay due to the completion of different application forms, delay in processing the application, and delay due to inappropriate requests such as for patients' and consultants' consent. The mean delay was 12 weeks (range 4-25 weeks).

The Department of Health's guidelines are unlikely to resolve the first two types of delay since they make no recommendations concerning a standard application form or the frequency of meetings of ethics committees.² The guidelines may compound the third type of delay since they state that "wherever possible consent should be sought from the health professional responsible for the relevant aspect of the subject's care" and from patients unless the local research ethics committee "is satisfied that the value of the project outweighs, in the public interest, the principle that individual consent should be obtained." Just as the guidelines fail to distinguish clinical studies from population based research our study suggests that this is happening at a local level.

Ethics committees were originally established to consider clinical studies, with the primary aim of safeguarding patients' interests. The protection of the doctor-patient relationship is the basis of asking the permission of the doctor in charge of the patient. In contrast to clinical studies, in which patients are always directly affected by the

proposed intervention, population research does not entail intervention, intrude on the doctor-patient relationship, or have any direct application to the patients under study. Many retrospective case note studies fall into this category; thus the current recommendation that patients and consultants should give consent is inappropriate for population research.

The Department of Health has attempted to get around the problem of multicentre research by suggesting that one local research ethics committee should consider the issue on behalf of neighbouring committees. But it does not mention how the committee would be nominated and what happens when centres for investigation are not covered by neighbouring and cooperating committees. There have been frequent calls for a national ethics committee to establish and monitor national policies and guidelines for local research ethics committees.^{3,4} Yet the Department of Health has failed to respond. Is this because of unpalatable resource implications because research, information, and monitoring systems would have to be established and local research ethics committees funded properly? If the government is committed to effective and efficient research a national ethics committee is one way forward.

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EDITOR,—P C E Moodie and T Marshall's comments about problems in obtaining ethical approval for multicentre studies¹ are exemplified by our recent experience with a nationwide epidemiological study of listeriosis, which entailed taking food histories from patients and matched controls.

Because the protocol, developed in response to the upsurge in listeriosis in 1987-8,² fell into the definition of research³ it was submitted to a national ethics committee and approved on condition that all district committees were also approached. Recognising the logistic problems, the national committee recommended that the study be advertised in the *Communicable Disease Report* of the Public Health Laboratory Service (received weekly by microbiologists and public health physicians throughout the United Kingdom) with an outline of its purposes and methodology and an invitation to districts, if they deemed it necessary, to ask the investigators to seek local approval.

There were 47 responses to the notice at intervals ranging between one and 42 (median three) weeks: four districts volunteered direct approval, 25 requested the protocol, and 18 sent application forms. The time to the committees' response ranged between three weeks and 11 months (median 15 weeks) for the "protocol only" submissions and up to 12 weeks after dispatch of the completed form for the remainder; two lost our applications, and three never responded in writing despite repeated requests.

There was diversity of practice: two committees required the investigator to hold a contract with their health authorities; one required the signature of all clinicians in the district whose patients might be involved; two required completion of further forms for the unit general manager and a separate general practice committee, respectively, after their own approval; and two separate applications

were required for the two committees in one district—the study was approved by one but not by the other (the only refusal).

Four committees requested 10-12 copies of all paperwork—over 500 sides of A4 paper per submission; postage costs alone for the formal submissions were over £30. Dissimilarity of the forms meant that, although there was a basic core of 16 questions, in practice over 75 different answers to them had to be devised.

Our experience shows that the machinery for obtaining timely and geographically comprehensive ethical approval for urgent national epidemiological studies does not exist. The advertisement was not the answer: we were uneasy about our position in non-responding districts, although there were no untoward events among the 583 interviews now completed. Furthermore, because the start of our study was substantially delayed and considerable extra resources consumed, we believe that legitimate research was impeded and that this in itself was unethical because earlier identification of vehicles of infection might have prevented at least some of the morbidity and mortality associated with listeriosis.

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EDITOR,—It was to meet the problems instanced by Peter Moodie¹ and R Horwitz and C H Cheetham² that the Royal College of General Practitioners established a central research ethics committee in 1982 under the then chairmanship of Sir Eric Scowen. Since then the committee has reviewed many multicentre trials, following a set of guidelines.³

In brief, the committee, which has among its members representatives from the Royal Colleges of Physicians, the Royal College of General Practitioners, and the Royal College of Nursing as well as a sociologist, a statistician, a clinical pharmacologist, an economist, and an ethicist, scrutinises protocols of studies to be carried out in the community in three or more districts.

Investigators are requested to notify the appropriate local ethics committee when approval has been given, so that local issues may be considered where relevant and the local ethics committee will be aware of studies being undertaken in its bailiwick. An annual report of the activities is published, and several hundred protocols have been reviewed over the years.

It is sad that there is still ignorance of the existence of just the sort of body that the *BMJ*'s correspondents wish to see functioning.

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- 1 Moodie P. The role of local research ethics committees. *BMJ* 1992;304:1129-30. (2 May.)
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Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.