not reflect these. From Randall and colleagues' paper we can tell that the risk due to smoking in south Bedfordshire is in line with the British average though the proportion with high blood pressure is lower owing to the lower age range.

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DNA fingerprinting and contact tracing

EDITOR, —DNA fingerprinting of human material has given great service in securing conviction in several trials for rape and murder. DNA fingerprinting of bacteria and viruses in a case in which A is alleged to have infected B can, however, strengthen the case for the defence—that is, if the strain infecting A differs from that infecting B. As Peter Godfrey-Faussett and colleagues point out, it is always possible that another infected person, C, is the common source for A and B.¹ DNA and other methods of fingerprinting bacteria and viruses are likely to become evidence for the prosecution only when A is alleged to have infected several people whose only common factor is a link with A and each is infected with a bacterium or virus with a fingerprint identical with that infecting A. This was the case when a dentist and several of his patients were found to be infected with the same strain of HIV.²

Contact tracing, which we carried out in the case reported by Godfrey-Faussett and colleagues, has limitations, being a descriptive exercise rather than one that tests a hypothesis. It can determine only time-space relationships and the possibility of transmission from A to B, not whether transmission is likely.

Godfrey-Faussett and colleagues' paper raises an additional issue in that, although it does not identify the subjects reported on, the case is well known and the local newspaper swiftly carried an article on it under the subheading "Genetic testing backs theory that neighbour was source of infection which killed toddler"; the article contained photographs and names.³ Should patients have the option to oppose the publication of their history even though they are not identified in the report and publication is in the interest of science?

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Patient's charter in outpatient services

EDITOR, —The letters¹⁻⁵ published in response to my editorial on implementing the patient's charter in outpatient services⁶ indicate the varying requirements in outpatient clinics in different specialties

in different parts of the country. Some specialties require continuing care from a specialist team.¹ Others can maintain satisfactory contact with patients by telephone,² and some deal with urgent rather than elective referrals, so that any delay in consultation could be detrimental.⁴ The 13 week limit between referral and the first outpatient appointment would not be appropriate for such services; it is, however, a regional standard for all specialties in the South Western region for 1993-4 and is an unattainable target for many. Non-urgent referrals in specialties such as plastic surgery, orthopaedics, ophthalmology, and, in many district general hospitals, ear, nose, and throat surgery, general surgery, oral surgery, dermatology, and neurology may have to wait six to 12 months. This is clearly unsatisfactory.

Michael P Corlett suggests one way of dealing with large numbers of elective referrals requiring straightforward operative care,³ and many specialties could develop their own mechanisms for getting the best out of the limited time available in outpatient clinics. When all this "efficiency" has been achieved the shortfall in staff in several specialties in hospitals throughout Britain will be obvious. To calculate the magnitude of that shortfall the finite capacity of the consultants and their teams will have to be clearly stated rather than the present unrecognised compromises in the quality of consultations be perpetuated. It is to enable such calculation to be made that the Royal College of Surgeons issued its guidance notes on the general surgical workload in the provider-purchaser contract.⁷

Quality measures based on the patient's charter and on regional and more local standards are now being incorporated in contracts for work between purchaser and provider units. Such measures are often added to historical workloads that entail the compromises in the quality of consultation that inevitably result from the standard practice of squeezing in more referrals than can be properly accommodated within the time available. There seems to be little understanding of the finite capacity of the clinicians who are the subject of such contracts. Moreover, because outpatient activity is common to almost all specialties it is likely to be in this that the gap between the level of service required by purchasers and that which providers can offer is made explicit.

It has been calculated that in England and Wales one consultant general surgeon is needed per 30 000 people, as is currently achieved in both Scotland and Northern Ireland; currently there is one per 50 000 people.

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Disintegration of civilian life in Myanmar

EDITOR, —The article about Burmese women refugees prompts me to write about the daily hardships suffered by ordinary citizens of Myanmar (formerly Burma) under the current military regime.¹

Basic commodities are available only from black

marketeers at highly inflated prices. This is the result of economic mismanagement by the military junta; every spare pyas (the money of Myanmar) is spent on developing and maintaining the military. The Democratic leader, Daw Aung San Su Kyi, who won the Nobel peace prize last year, is still under house arrest. The country has declared itself the poorest country in the world in order to exempt itself from interest payments on its debts. The country's rubies, emeralds, teak, and oil are no longer in the hands of the people of Myanmar but sold to meet the costs of the military's excesses. There is no social policy. Families are separated because they have had to flee to escape the military's atrocities. Those who remain in the country are barely surviving. Orphans and elderly people, who would normally fit into extended families, are cared for by distant relatives and neighbours. There are no social services to care for the needy, and the health service provision is completely inadequate.

The general hospital, with its Victorian architecture, in the centre of Rangoon has outlived its useful life and, owing to lack of investment and maintenance, is on the verge of collapse. Wards are overcrowded, and patients have to take their own medicine for treatment. These medicines are bought from black marketeers; they are usually out of date and adulterated and have not been kept at recommended temperatures. Hospital doctors employed by the military junta are poorly paid. Their salaries are similar to those in prewar days and do not keep up with inflation. In order to survive most doctors carry out private practice during unsocial hours. In contrast to services provided for ordinary citizens, military hospitals are well funded.

The education system has collapsed. Schools, colleges, and universities were closed during the period of mass protest by the population in 1989. They remain closed since the whole system has disintegrated, with buildings in ruin, facilities and equipment in need of replacement, and the disappearance of lecturers, tutors, and teachers who spoke defiantly against the military.

Doctors, whether civilian or military, are starved of knowledge. All post arriving in Myanmar is censored unless approval from a higher authority has been obtained in advance. Doctors in Myanmar are pleading to their medical colleagues outside the country to send any medical journals, newspapers, books, and magazines by any means available to enlighten and update their medical knowledge. This would be some small consolation in their otherwise miserable lives.

1 Hilsom L. Burmese women refugees need women health workers. *BMJ* 1992;304:365. (4 April.)

**The author's name has been withheld to protect friends and relatives. —ED, *BMJ*.

BMA policy and fundholding

EDITOR, —The BMA has been bruised by the recent years of agonising over the introduction of market forces into the delivery of health care and its unsuccessful attempts to modify what were perceived to be potentially damaging and divisive changes to the NHS. Many doctors believe that the most controversial of the changes is the introduction of fundholding. At the recent annual representative meeting in Nottingham the representatives were denied an opportunity to debate the current policy on fundholding, although clearly this continues to cause great anxiety across the breadth of the profession, as evidenced by the motions on the agenda.

The leadership of the General Medical Services Committee clearly has a difficult path to tread. As fundholding is now established, for the immediate