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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1 Randall T, Muir J, Mant D. Choosing the preventive workload in general practice: practical application of the Coronary Prevention Group guidelines and Dundee coronary risk-disk. *BMJ* 1992;305:227-31. (25 July.)

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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2 Ciesielski C, Marianos D, Ou CY, Dumbaugh R, Witte J, Berkelman R, et al. Transmission of human immunodeficiency virus in a dental practice. *Ann Intern Med* 1992;116:798-805.

3 Handley A. DNA technique used in TB study. *Coventry Evening Telegraph* 1992 July 25.

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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1 Gutch RE. Implementing patient's charter in outpatient services. *BMJ* 1992;305:55. (4 July.)

2 Fitzgerald MR. Implementing patient's charter in outpatient services. *BMJ* 1992;305:55-6. (4 July.)

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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

future at any rate, Dr Ian Bogle and his team stated that they wished to feel their way forward, accommodating fundholders, but had to do so without offending the majority of general practitioners who oppose the concept and our hospital colleagues, who rightly feel threatened by it.¹ Their task is made more difficult as they are shackled by both the GMSC's and the BMA's policy opposing fundholding.

The fact that fundholding was not debated at the annual representative meeting suggests to me that the leadership feared that the current policy would be endorsed, making public the discomfiture of the negotiating team and the division within the profession. I expect the hope is that time and pragmatism will resolve the problem and that the policy will ultimately be changed, perhaps at the next annual representative meeting. This is a high risk strategy as the cracks are likely to be showing more next year than this. I believe that such fundamental difficulties are best faced early, however uncomfortable they are, as postponement usually makes the differences more entrenched.

The association missed an opportunity either to state that it now supports fundholding or to accept publicly that, though it continues to oppose the concept, it will work with the concept to ensure the minimum damage to patients' care. Had the debate been held and the present policy endorsed the signals would have been clear and the consequences would rest with the membership. The members of the association are democratic, and opponents of fundholding, such as myself, would accept a change of policy after a thorough debate. What is more difficult to accept is the leadership avowing one policy and practising another. The responsibility of leaders in an association such as the BMA is to carry out policy or to persuade the membership that the policy is inappropriate and to generate change.

The current situation pleases no one and makes the association look foolish and the leadership less than strong.

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1 The week in Nottingham: building bridges. *BMJ* 1992;305:193-4. (18 July.)

Induction of house officers

EDITOR,—Mollie McBride rightly sees a role for general practitioners in the education of house officers,¹ and this should extend beyond the vital induction course. The acknowledged success of vocational training in general practice has given many trainers skills that can helpfully be used by others. Some trainers now have spare capacity because of the recession in vocational training.

Each hospital employing house officers should have a preregistration tutor whose task is to supervise, facilitate, and develop all aspects of teaching for the new doctors. His or her priorities would be educational and the remit broadly based to include pastoral care and career advice for the holders of these stressful posts. The curriculum for the year has now been established by the General Medical Council. Consultants have their own priorities, which a preregistration tutor could collate, along with the existing teaching resources that abound in every hospital.

Those concerned with the preregistration year tend to despair at the monumental task of changing the manpower demands of the service to let a little education in. A more optimistic approach is to start the educational initiative now; the manpower changes will follow. General practice trainers could be key people in establishing a worthwhile educational structure to the year. They have the experience and personal contacts to do it and

would, I suspect, discover much common ground with the primary care doctors of the hospital service.

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1 McBride M. Induction of house officers. *BMJ* 1992;305:185. (18 July.)

EDITOR,—Our induction course has been radically changed for this month's intake of preregistration house officers and shares many of the ideas put forward by Rodney Gale and colleagues.¹ The gulf between final year medical student and house officer is huge. In many ways this transition period is poorly supervised. Our general induction took place on 31 July, and management agreed to pay the doctors for one extra day. The content of the day has changed: it no longer hinges on matters such as safety regulations and how to use the laboratories. The emphasis has shifted towards discussing the role of the preregistration house officer as a team member on the ward and in the hospital as a whole—for example, in relation to general practitioners. There is also a focus on pastoral matters.

The second part of the induction comprises six lunchtime meetings on consecutive Wednesdays. All the consultants with a preregistration house officer attached to their firm have agreed to that house officer attending each week for one hour, and the senior house officers have agreed to carry the preregistration house officer's bleeps. The topics for the lunchtime meetings were picked in a group discussion with junior doctors: bereavement counselling and dealing with the coroner; managing intravenous lines and Hickman lines and giving cytotoxic drugs; doctors and solicitors; doctors and defence organisations; managing pain; and stress. These subjects are poorly dealt with in undergraduate training and are particularly relevant in the first few weeks of the preregistration house officer's job.

The third part of our induction is a handbook for house officers set up in a similar way to that described by Gale and colleagues. The contents of the handbook and the lunchtime meetings will be reviewed annually, and the stimulus for change should come from the preregistration house officers.

Setting up these three aspects of induction has been stimulating both for us and for others. Groups such as consultants, the social work department, and liaison nurses have asked us to include particular information or clarify their roles. Senior house officers have asked if they might attend parts of the course or have a similar one organised for them. This is encouraging as it suggests a general realisation that in the past preregistration house officers have been poorly catered for and deserve better.

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1 Gale R, Jackson G, Nicholls M. How to run an induction meeting for house officers. *BMJ* 1992;304:1619-20. (20 June.)

Primary health care teams

EDITOR,—I am surprised that, in his article on primary health care teams, John Hasler fails to refer to a salient report.¹ By the late 1970s the teams were disintegrating, so the Department of Health and Social Security set up a joint working group on the primary health care team under the chairmanship of Dr Wilfred Harding.² The

group's remit was "to examine problems associated with the establishment and operation of primary health care teams and to recommend solutions."

The working group made 50 recommendations; recommendation 22 stated "that in the longer term health authorities should make sufficient resources available to enable these nurses [practice nurses] to be employed within the normal NHS structure in a fully integrated nursing service without prejudice to existing arrangements where these are working satisfactorily." Unfortunately, this integration never occurred so that now practice nurses screen well patients and the district nursing service is overloaded with looking after ill patients. Indeed, Hasler points out that the new contract has stimulated further increases in the number of practice nurses to undertake health checks and work in special clinics for which there is payment.

Hasler regrets that the attached members of the team are employed by an external body and are not responsible for contracting with the general practitioners. Surely a lesson was learnt in the '70s when in the Court report health visitors were criticised for having relaxed their surveillance on children's health by reducing their visits to children under 5 from 93% in 1964 to 67% in 1974.³ This was partly responsible for the reduction in the primary immunisation rate and the recurrence of epidemics of whooping cough. It became clear that the health authorities were more concerned with the health issues in the population at large than the general practitioners looking for help in their practice work and delegating responsibility to health service nurses on that basis. It is doubtful if that mistake would be made again.

Hasler claims that the potential for new ways of delivering primary care have never been greater. It looks as though he is referring to the care of the fit population because he does not refer to the care of seriously ill or chronically ill patients at home. The new contract does not seem to have improved this aspect of care—indeed, home care may have declined because of the concentration of remunerated work in surgery premises.

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1 Hasler J. The primary health care team: history and contractual farces. *BMJ* 1992;305:232-4. (25 July.)

2 Department of Health and Social Security. *Report of the joint working group on the primary health care team*. London: DHSS, 1981. (DA(81)13.)

3 Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976. (Court report.)

Role of Western public health in the "new world order"

EDITOR,—The Commonwealth of Independent States and eastern Europe are regressing rapidly with respect to leading health indicators.¹⁻³ Public health infrastructure is in decay; health care relies excessively on the hospital as a provider of primary services.³ Life expectancy in Eurasia is five years shorter at birth and two years shorter at age 65 than in the United States.³ Infant mortality is 25.1/1000 live births compared with 10.4/1000 in the US, and maternal mortality is six times that in the US. The overall age adjusted death rate in Eurasia is 1160 deaths/100 000 compared with 821/100 000 in the US.³ In addition, the environment in the Commonwealth of Independent States is emerging as one of globally unprecedented disaster, the health effects of which are only starting to be assessed. This is occurring during the greatest period of economic transition and social dislocation to which a civilian population has been subjected, other than in wartime, this century.

Major Eurasian health problems are preventable or remediable.⁴ Western primary care, public health, and epidemiological centres should become