operative complications and therefore the day-case unit is not a suitable place for basic surgical training. All trainees should, however, benefit from experience in the day-case unit." With the high level of day surgery in the United States much of trainees' teaching there must obviously go on in that setting. One of us (RH) performs 40% of his cataract operations as day cases and finds no real difficulty in teaching junior staff members while so doing. We certainly agree with Alistair R Fielder that this issue must not be used to stem the development of day case cataract surgery.

Colin Dryden may be correct in claiming that modern general anaesthesia has many of the benefits associated with local anaesthesia.² A recent study of cataract surgery comparing general anaesthesia with local anaesthesia found, however, that local anaesthesia was 15 times cheaper in material, led to a faster throughput of patients in the operating theatre, and halved the expenditure on staff (ophthalmologists gave the local anaesthetic).³ These are important factors where waiting lists are long or units are competing to obtain contracts for work. Patients' opinions are hard to gauge, but a small study of 24 patients with cataract suggested a preference for local anaesthesia.⁴

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- 1 College of Ophthalmologists. *Day case surgery in ophthalmology*. London: College of Ophthalmologists, 1991.
- 2 Dryden C. Day surgery for cataracts. *BMJ* 1992;305:713. (19 September.)
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EDITOR,—Hugh F Thomas and Roger Humphry assert that "undoubtedly . . . the impetus for day case surgery [in the United States] has come from insurance companies because it is cheaper." I recently reviewed day case surgery in the northern region and visited the Methodist Medical Center in Illinois. The authors are right to point out that the high proportion of day case surgery for cataracts in the US is not associated with poorer outcome or other disadvantages to patients but are wrong to assume that the primary impetus is price. The Methodist Medical Center does 99% of its cataract surgery as a day case procedure.

The main impetus for the remarkable performance derives from the following facts.

Firstly, the patients want day case surgery. The elderly population in the US is vocal, mobile, active, and on the whole made up of discerning consumers.

Secondly, the clinicians want day case surgery. Most of the work entailed in the preoperative assessment, admission, discharge, and follow up of patients and in audit of day case procedures is done by registered nurses according to agreed, written protocols and recovery criteria. This allows the surgeons to turn up in the theatre, operate, and leave. Their incentives for day case surgery include the absence of any follow up ward rounds.

Thirdly, the employers and insurance companies want day case surgery. Price itself is not a factor because despite cost differences the price that units charge for inpatient or outpatient procedures is the same. Pricing policy allows ambulatory care to cross subsidise extensive inpatient capacity, not necessarily to save the purchaser money. The overall cost is less because recovery time is shorter and patients can return to work sooner. That is the incentive, not the relative cheapness of the procedure.

For many reasons the American experience cannot be repeated in Britain. Currently, patients' expectations may be different. An overcrowded outpatient clinic makes follow up on the first postoperative day a completely different experience

from the "office based practice" of a specialist in the US. But there are many lessons for both purchasers and providers in Britain—for example, because of our enhanced ability to control costs there are genuine revenue implications for the NHS in a shift to day case surgery.

The main issues of day case surgery are better outcome, higher quality of service, equity, and the ethical use of resources.

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- 1 Thomas HF, Humphry R. Day surgery for cataracts. *BMJ* 1992;305:536-7. (5 September.)

Setting up a practice newsletter

EDITOR,—Tim Albert's article on setting up a newsletter raises many issues¹; he does not, however, touch on that of distribution. To have impact the newsletter should reach the practice population rapidly. The only way to do this is by post, and a practice with a list of 10 000 patients might well find the cost of including every household—around £800—unacceptable. Alternatively, newsletters could be included with every mailing for other purposes (immunisations, cervical smears, health promotion recalls, or repeat prescriptions). Other patients could obtain copies from the waiting room or reception desk on a "help yourself" basis.

The value of a newsletter in general practice is hard to define. What about advertising services offered by the practice? This is better served by the practice information leaflet. What would constitute "news" and give the feel of a homely caring group of family doctors—staff births, deaths, marriages, the Christmas party, refurbishments, research undertaken, awards achieved? Good for morale (of staff only) but egotistical and unlikely to modify patients' behaviour. How about providing articles on managing self limiting illness? Inadvisable. Propaganda—for example, how hard we work, or appropriate use of the out of hours service? Albert points out that this will be scoffed at. Patients might be interested in audit of aspects of care and an evaluation of the practice output, but this would be best served by an annual report.

The benefit of a newsletter is undeniable when a practice is undergoing change, to provide reassurance if nothing else. Rumours abound in local communities, and health care is emotive. Newsletters could explain the reasons for moving premises, changes in consulting times, a decision to become fundholding, the new trainee, and so on. For this purpose newsletters make fiscal sense. Patients are unlikely to join a practice because of a newsletter, which they are unlikely to see. Newsletters might, however, prevent an exodus. Newsletters will burn a sizeable hole in the practice purse and, worse, will require days of extra work. Before embarking on this venture be sure you have a clear objective and decide how you intend to achieve it.

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- 1 Albert T. How to set up a newsletter. *BMJ* 1992;305:631-5. (12 September.)

Screening, ethics, and the law

EDITOR,—We are concerned that the editorial by P J Edwards and D M B Hall does not give appropriate guidance.¹ It confuses research and service activities.

It is incorrect to say that the novel implementa-

tion of an effective screening procedure should be regarded as research. This requirement would mean that screening might not be introduced because its funding would fall between two stools: health authorities would not fund research, and bodies that do fund research would not fund an activity of proved efficacy and safety. Edwards and Hall do not make explicit the need to develop national mechanisms for assessing the efficacy and safety of new screening tests and for the controlled implementation of new screening programmes of proved value, with audit of the service and the quality of care. Monitoring and refinements should be regarded as an integral part of the service, not a separate research activity.

Screening procedures of unknown effectiveness and safety should not be introduced as service activities; research designed to resolve the uncertainty is essential. Such research can be based on observational data (as with antenatal screening) but may require a randomised controlled trial. Confusing research and service may delay the introduction of worthwhile screening programmes and also encourage the introduction of ineffective programmes provided they have been approved as ethically acceptable by an ethical committee.

Of course people offered a screening test must know what is going on, but how this is done and the extent of detail provided need be considered carefully and a reasonable judgment reached. Too much information can be as unsatisfactory as too little. The detail will vary according to the test or procedure, the expectations of the people being screened, and the individual person concerned. The editorial is too prescriptive about this, and its suggestion that a doctor could be successfully sued for negligence unless detailed information was provided at the outset may be a self fulfilling prophecy. In antenatal screening, for example, the editorial advocates that women should be told the rates of false positive and false negative results and the risk of amniocentesis causing miscarriage. Such detail may be appropriate before the amniocentesis but not when offering the initial blood test, nor to avoid "disastrous legal consequences." The approach proposed will not always suit specific circumstances, yet screening authorities may feel obliged to comply through fear of legal action regardless of its overall merit. It will have the effect of encouraging defensive medicine.

Nobody would dispute that screening programmes must be worth while and delivered to the public effectively, economically, equitably, and with appropriate monitoring. The real problem is the need to establish a national mechanism within the health service for doing this instead of leaving the matter to individual units throughout the country. It will not be helped by calling a service programme a research project or by encouraging defensive medical practice.

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- 1 Edwards PJ, Hall DMB. Screening, ethics, and the law. *BMJ* 1992;305:267-8. (1 August.)

Service increment for teaching and research

EDITOR,—Trevor A Sheldon¹ infers that the King's model for allocating the service increment for teaching and research (SIFTR) within its provider unit² is founded on an untenable assumption and underwrites inefficiencies. We believe that he has misunderstood the approach that we have taken.

The King's model undertakes a preliminary distribution of SIFTR to specialties that is not

based solely on student numbers but also takes account of proxy measures of research activity to reflect the impact of both teaching and research on service costs. This is precisely what SIFTR is intended to do—that is, to compensate for these justifiable excess costs and make prices in teaching and non-teaching hospitals comparable within the internal market.

The subsequent weighting of the distribution by the excess costs of specialties is done to identify where there are discrepancies. This then enables the school and its provider unit to investigate these costs, in consultation with care group directors, to highlight excess costs that are arising outside teaching and research—for example, due to complex case mix—which should be recouped through service contracts, and inefficiencies that can be dealt with managerially. This is seen by King's and its provider unit as being the considerable advantage attached to this model.

Sheldon is right to highlight the importance of monitoring the quantity and quality of teaching undertaken by NHS teachers. In the case of King's this is covered in the terms of the SIFTR contract that the regional health authority has taken out with the provider unit, but this was not the subject of our paper, which instead concentrated on the process of allocating resources.

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- 1 Sheldon TA. Service increment for teaching and research. *BMJ* 1992;305:310. (1 August.)
2 Clack GB, Bevan G, Peters TJ, Eddleston ALWF. King's model for allocating service increment for teaching and research (SIFTR). *BMJ* 1992;305:95-6. (11 July.)

Tobacco advertising

EDITOR,—John Belloch¹ does little to answer the concerns expressed by Selena Gray and colleagues.² Although there is a commitment in last year's renegotiated voluntary agreement on tobacco advertising to reduce the number of advertisements on retailers' premises evenly by time and by type of material, the tobacco industry is at liberty to replace many shoddy small stickers and signs with fewer large, high impact advertisements. Even reduction across geographical base remains vague. There is a well documented tendency for tobacco advertising to be concentrated in poorer areas,^{3,4} so audit by sufficiently small area will be required to ensure a genuine reduction for all sections of the population.

Taking appropriate action will presumably reflect the committee's current approach: to ask the tobacco company concerned to investigate itself; to report back eventually; to adhere to the letter but not the spirit of the agreement, except where it is to the industry's advantage to ignore the strict letter; and to take no action except to remove the particular example of an advertisement that breaches the agreement.

The most telling indictment of the present system of monitoring is the answer to a recent parliamentary question: for 1989-90 and 1990-1 official government figures show that 35% and 77%, respectively, of all breaches of the voluntary agreement in Britain occurred in Oxford.⁴ This is obviously unlikely and reflects a lack of monitoring, making nonsense of Belloch's assertions regarding his committee's arrangements. It also exposes the government's complacent endorsement of the voluntary agreements "to control tobacco advertising... in an effective... way" (R Greig, Department of Health, personal communication) for the sham it is. Anyone with any intelligence knows that tobacco promotion reaches children, yet "the Government believes that the best way to control tobacco advertising and promotion is

through the voluntary agreements" (B Mawhinney, personal communication). These cosy arrangements are best for the tobacco industry.

Every day 450 more children start smoking,⁵ encouraged to a considerable extent by the exciting and intriguing promotion they see all around them. It is time for the government to ban tobacco advertising instead of sacrificing children's future health to current political expediency.

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5 Royal College of Physicians. *Smoking and the young*. London: RCP, 1992.

Developing a district diabetic register

EDITOR,—S D Burnett and colleagues provide a useful account of data sources available for developing a diabetic register.¹ What they describe, however, is a "hospital catchment area" register, not a district register, which is what they refer to in their introduction. The problem with a hospital catchment area register is that it has no definable population denominator, and, as Liam Donaldson states in his editorial in the same issue, registers without a natural population base have limited applicability.²

Establishing a district diabetic register is an even more difficult task: not only would cases identified from the data sources described by Burnett and colleagues need further sorting by postcode (which would have to be done manually for the Prescription Pricing Authority returns), but a wider net would need to be cast to include all hospitals and practices serving the district's population. As clinicians and general practitioners would have few incentives to update and maintain a register not designed to suit their purposes a district health authority would probably want to derive its data from the hospital and general practitioner registers.

As Donaldson states, a district diabetic register would be invaluable for assessing needs and monitoring outcomes²; purchasing district health authorities should consider rising to the challenge.

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- 1 Burnett SD, Woolf CM, Yudkin JS. Developing a district diabetic register. *BMJ* 1992;305:627-30. (12 September.)
2 Donaldson L. Registering a need. *BMJ* 1992;305:597-8. (12 September.)

EDITOR,—We agree with S D Burnett and colleagues that identifying all diabetic patients registered with a practice is an essential starting point for structured care.¹ We have reservations, however, about such a register being held by a district general hospital.

We believe that obtaining names of patients from the Prescription Pricing Authority and the family health services authority exemption certificates could breach confidentiality. We acknowledge that the use of exemption certificates was agreed in principle by the family health services authorities concerned but we question whether this release of information to the authors was covered by their registration under the Data Protection Act. We believe that in these circumstances patients' consent must be first obtained.

Burnett and colleagues do not discuss confi-

dentiality in the context of a centrally held register in any great depth. The BMA's policy is that "A patient's general authority may be assumed for the necessary sharing of information with other health professionals concerned with his health care, both for any particular episode and, where essential, for his continuing care. However, beyond this the patient's express consent must be obtained before any disclosure is made."² We believe that patients who are not treated by, or who have not been referred to, a hospital should not have their names included on the hospital register without their informed consent.

We support programmes established for audit and to encourage standards of excellence. The data, held with explicit safeguards to prevent the identification of patients if their informed consent has not been gained, will also serve as epidemiological data for research purposes.

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- 1 Burnett SD, Woolf CM, Yudkin JS. Developing a district diabetic register. *BMJ* 1992;305:627-30.
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Applying for disability living allowance

EDITOR,—An astonishing half of the disabled people questioned in a survey by the Automobile Association avoided claiming the mobility allowance (now called the disability living allowance) because they did not want a physical examination or were concerned about being humiliated or unfairly judged by the examining doctor.¹ These concerns are known to the Department of Social Security, and its procedures were modified with the introduction of the disability living allowance. This has introduced the idea of self assessment, whereby most claims are decided mainly on the customers' own assessment of how their disability or illness affects them, rather than relying on an examining medical practitioner's report. A visit by a doctor working for the Department of Social Security is now the exception rather than the norm. In the department's manual the instructions for examining doctors say:²

(1) Your assessment of the customer's walking ability should be based on informal observation not by a formal walking test.

(2) If a person's walking ability varies, take account of their overall ability over a period of time not just their ability on the day of the examination.

(3) In general you should always ask to examine the customer, but if they decline, their wishes should be respected.

(4) When carrying out an examination, the dignity and feelings of the customer must always be respected and at no time should they be asked to perform any action they would find distressing or painful.

I am concerned that so many disabled people are not applying for this allowance owing to anxieties about the medical examination. As a profession we need to be alert to this and to do what we can to ease these fears; we need to increase the rate of applications for the benefit and uptake by those who qualify.

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- 1 Godlee F. Disabled drivers not getting advice from doctors. *BMJ* 1992;305:670. (19 September.)
2 Department of Social Security Benefits Agency. *Guidance for examining medical practitioners*. London: Benefits Agency, 1992.