consent, as they move within the NHS, house officers may be unaware that they are not protected against prescribed diseases such as tuberculosis and hepatitis B. It may well be that Lewisham Hospital's handbook mentions the occupational health department.

Luisa Dillner's review of *Stress and the Medical Profession* seems to confirm my views.² The penultimate paragraph suggests that doctors need an accessible counselling service and an occupational health service that is geared to recognising stress.

The standard and quality of occupational health services vary considerably within the NHS, but it is essential that all staff, including doctors, become more aware of the services they offer.

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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.)
2 Dillner L. "Avoidable" pressures could relieve doctors' stress. *BMJ* 1992;304:1587. (20 June.)

Unnecessary hospitalisation in a psychiatric rehabilitation unit

EDITOR,—Peter H Dick and colleagues' paper highlighting delayed discharges from the Dundee psychiatric rehabilitation unit raises several points of interest to doctors in all specialties.¹ The title and introduction led us to believe that concrete proposals leading to more rapid turnover of beds would be discussed, but, sadly, they are not.

Discharge to unsuitable accommodation is mentioned and may be one method of unblocking beds in the short term. In our experience this practice often leads to rapid readmission. If the original discharging psychiatric unit or other psychiatric departments are unable to readmit these patients then either an acute medical unit or an acute geriatric unit becomes involved.

From the figures given we see that the average turnover of the Dundee rehabilitation unit is just under one patient a week, but we are not given the number of beds in the unit. As the number of beds available is often limited geriatricians may have acute geriatric beds blocked by patients awaiting transfer to their local psychiatric unit. Bed blocking and delayed discharges can therefore affect many specialties either directly or indirectly.

Our department uses a multidisciplinary team to identify potential problems with discharge soon after patients' arrival. This team meets each week to discuss all patients in the department. By highlighting potential problems at an early stage we aim to decrease the time spent in an acute hospital bed.

Bed blocking is a problem in all specialties. We are fortunate in having both government funded and privately funded residential accommodation and nursing home facilities which act as an extension of geriatric long term care beds. We wonder if the previous policy of closing long term psychiatric beds without adequate funding for alternative accommodation in the community may have played a part in the present situation.

We are concerned that this problem may become more pronounced when the change in funding for community long term care from the government (Department of Social Security) to local authorities takes place next April.

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1 Dick PH, Crombie IK, Durham T, McFee C, Primrose M, Mitchell S. Unnecessary hospitalisation in a psychiatric rehabilitation unit. *BMJ* 1992;304:1544. (13 June.)

Ernest Saunders: diagnostic dilemma

EDITOR,—In passing judgment on the basis of what they have read in the newspapers regarding the medical evidence in Mr Ernest Saunders's appeal Robert Howard and colleagues are guilty of the very accusation they make: of basing definite views on inadequate information.¹ They also lose sight of the fact that the Appeal Court is not a clinical case conference. If that was so the issue of presenile dementia would not have been raised in front of Mr Saunders let alone the world in general.

The case against his deterioration in prison being due to a dementia was well presented by Dr George Perkin, who considered that any decision should be delayed. It was made clear by everyone who gave evidence that the diagnosis was not certain, and in a different situation one would obviously have waited for less equivocal diagnostic evidence. Their lordships no doubt took the view that it was better to be safe than sorry and reduced Mr Saunders's prison term to reflect their concern. Considering that Mr Saunders had already served a prison sentence for a first offence of theft, they thereby eschewed the possibility of him spending further time in penal conditions if in fact his days were so grimly numbered.

Some people seem angry about the case, feeling cheated of their pound of flesh and that Mr Saunders has a duty to deteriorate to provide it. I am sure that Howard and colleagues have no such base motives but are entirely concerned with the credibility of their specialty. Specialties of all sorts, however, need to be put in the human context that prevails in relation to individual cases, and the Appeal Court had the advantage, which Howard and colleagues have not, of weighing the clinical evidence within the wider context of the judicial situation. I am sure that Howard and colleagues will want to join me in expressing pleasure that Mr Saunders is apparently so much better.

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1 Howard R, Levestone S, Levy R. Ernest Saunders: diagnostic dilemma. *BMJ* 1992;304:1568. (13 June.)

Patient's charter in outpatient services

EDITOR,—In his editorial Charles Collins states that specialty outpatient clinics will have to develop a rigid booking pattern to be able to give specific appointment times but does not mention how specialties outside surgery will achieve this with present resources or the loss of the flexibility that allows patients with serious conditions to be seen quickly without admission to a scarce inpatient bed.¹

In oncology, with an open booking system and a varying number of new patients each week, there will inevitably be differences in waiting time, often over the 30 minute target. But the advantages to patients of reducing their waiting time at home and the accompanying anxiety, the early discussion of their diagnosis and treatment plan, and reducing the time to the start of treatment outweigh the wait in the clinic. If patients are informed of the size of the clinic and the reasons for the delay they are almost always sympathetic to the staff's problem. The alternative is ever lengthening outpatient waiting lists and an implicit selection process for treatment based on who has or has not succumbed while on the waiting list.

The editorial mentions a limit of 13 weeks between referral and first outpatient appointment, but again no qualitative weight is added to this. I doubt that a woman presenting with a breast lump or a man with a testicular swelling would consider

such a wait an improvement in the quality of service.

Follow up visits should also be more structured, according to Collins. Certainly the overall number and frequency of visits could be reduced with no loss of quality, but more structuring also leads to loss of flexibility, which impairs local response to changing demands: with more structured clinics it is harder to arrange an appointment at short notice. Both routine follow up and non-routine interval visits are important in detecting recurrence of cancer,² though they may be less important after some surgical procedures.³

As with much of the present reform in the NHS, the end points indicating quality of care that are harder to measure are being sacrificed for those that are easier to measure, such as outpatient waiting times, which are often less relevant to patients' overall satisfaction, utility, and outcome.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;304:1396. (30 May.)
2 Dewar JA, Kerr GR. Value of routine follow up of women treated for early carcinoma of the breast. *BMJ* 1985;291:1464-7.
3 Coggon D, Goldacre MJ. Outpatient follow-up after appendectomy. *Lancet* 1976;i:1346-7.

EDITOR,—Charles Collins's editorial on organising outpatient services to comply with the patient's charter proposes guidelines for consultation times in surgical outpatient clinics and states that efficient referral patterns may obviate the need for some outpatient attendances.¹

In 1990 I reviewed all patients admitted to Sandwell District General Hospital for hernia repair during 1989 to audit assessment of patients' fitness for anaesthesia as detailed in the notes and to propose a standardised referral letter for patients with a hernia, including a questionnaire designed to identify those with potential problems regarding anaesthesia. The proposed questionnaire asked for a brief history of cardiac and respiratory disease and diabetes; current drug treatment; recent blood pressure and pulse rate; and results of analysis of urine. These details would require little extra time to provide on referral, particularly if practice records were computerised.

A total of 269 patients were reviewed. Problems of potential relevance to anaesthesia or general postoperative care were identified in 74 patients. Problems were documented in the note of the initial outpatient consultation for 40 of these patients, and for only 37 of the 70 patients referred by general practitioners (four patients were internal referrals) was a problem identified in the referral letter. The questionnaire would have identified all but two of these problems (table); an outpatient visit would be unlikely to have identified the two other problems (one heart murmur, one acute chest infection). Six operations were cancelled during the year, including those for the patients with a heart murmur and acute chest infection; the four other problems would have been identified

Problems identified by proposed questionnaire

Problem	No	Cancelled operations
Hypertension	33	2*
Cardiac disease	13	3†
Chronic airway disease	15	1‡
Asthma	5	
Diabetes	5	
Oral contraception	1	
Thyrototoxicosis	1	
Steroid treatment	1	
Total	74	

Operations cancelled because of *uncontrolled hypertension; †atrial fibrillation, congestive cardiac failure, and heart murmur; ‡acute exacerbation.

by the questionnaire, allowing treatment before admission.

Surgical clinics fulfil three objectives: the diagnosis is considered, the patient's suitability for surgery and in particular anaesthesia is assessed, and diagnosis and treatment are discussed. Taking these points in reverse order, the implications of the diagnosis and treatment could easily be conveyed by letter, and the second objective could be covered by the questionnaire. I reviewed only patients admitted for operation and therefore did not address the first objective, but in most cases the diagnosis of hernia is obvious, and uncertain cases could still be assessed in outpatient clinics.

Collins points out that general practitioners are usually willing to follow up surgical cases, and it seems that the function of the preoperative outpatient appointment could often be undertaken by the patient's general practitioner. This would help to allow more complex consultations the 20 minutes that Collins recommends and prevent unnecessary waiting in busy clinics for patients with straightforward problems.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;304:1396. (30 May.)

International debt, death squads, and children

EDITOR,—Dorothy Logie's article on international debt casts a quite unjustifiable slur on Amnesty International in describing Amnesty as "distracting attention from the real exterminator of Brazilian children—namely, the burden of international debt."¹ This is a staggering misrepresentation of the facts. While it is incontestable that the root cause of the existence of street children is poverty and that poverty is inextricably linked to mortality, the brutality, torture, and murder in which the death squads indulge are extra horrors deliberately inflicted on the children. The horrifying photograph that accompanies the article, of a pile of bodies of children shot dead in Rio de Janeiro, is a clear illustration of the point.

Numbers of street children are unfortunately increasing in many Third World countries afflicted with international debt and other causes of poverty. Only in countries such as Brazil, Bolivia, and Guatemala are death squads made up of police and military personnel targeting the lives of such unfortunate young victims.

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1 Logie D. The great exterminator of children. *BMJ* 1992;304:1423-6. (30 May.)

AUTHOR'S REPLY,—The sentiments expressed in the opening paragraphs of my article are not mine but those of Dr Lauro Monteiro, a paediatrician who has dedicated many years to organising medical and legal help for thousands of street children in Rio de Janeiro. He fully acknowledges (as I do) Amnesty's excellent contribution in publicising the atrocities and murder of the children. The horrifying photograph of dead children is his. Two years ago, however, when Amnesty (along with other organisations) launched a worldwide campaign to focus attention on the killings, he considered that the international effort and outcry might have been more usefully focused on the injustice of international debt. As a Brazilian paediatrician, he sees debt killing many more children each year than either police or vigilantes but not attracting the same international outrage.

I am sorry that Amnesty has taken offence for it does excellent work. It is not an "either/or" situation: both debt and the murder of children need to be brought to the world's attention.

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"Gold standard" is an appropriate term

EDITOR,—P Finbarr Duggan draws attention to the fact that the term "gold standard" is being used more frequently in scientific work.¹ He sees this as a lamentable trend, but I take the opposite view. The gold standard is not the perfect test but merely the best available test.² The *Oxford English Dictionary* states that it is a "measure to which others conform or by which the accuracy of others is judged . . . ; thing serving as a basis for comparison."

As science increases its hold on the practice of medicine we become more aware of the limitations of the clinical method. Unfortunately, we also become more aware of the limitations of various diagnostic tests. Nevertheless, at any given time there may well be a consensus that a given test in a given situation is the best available test. It therefore serves as the gold standard against which newer tests can be compared. When enough data have accumulated to make that gold standard untenable it can perfectly reasonably be replaced by another. This can then preside until it too is toppled.

Duggan states that because the subject is in a state of perpetual evolution gold standards are, by definition, almost never reached. On the contrary, it is absolute truth that is never reached; gold standards are constantly challenged and superseded when appropriate.

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1 Duggan PF. Time to abolish "gold standard." *BMJ* 1992;304:1568-9. (13 June.)
2 Versi E. Discriminant analysis of urethral pressure profilometry data for the diagnosis of genuine stress incontinence. *Br J Obstet Gynaecol* 1990;97:251-9.

Dispensing doctors

EDITOR,—John Warden is right that dispensing doctors have reason to feel nervous about the exchange in the House of Lords on 13 June, but they have no reason to be surprised by the health minister's comments, which have remained unchanged for many years.¹

A comment made twice in the same debate by Baroness Cumberlege (parliamentary under secretary of state at the Department of Health), however, gives the whole profession much food for thought since it is unexplained. She drew attention to a "conflict of interest which potentially exists when one person both prescribes and dispenses."

Is she suggesting that general practitioners are

potential thieves and fraudsters, or could it be that the department thinks that doctors prescribe to "line their own pockets" as the pharmacists would have the uninitiated believe? Does the Baroness Cumberlege think that dispensing doctors may prescribe inappropriately for their own profit?

These alternatives are insults to general practitioners. On close examination the Prescription Pricing Authority's annual reports for 1985-91 firmly disprove the second alternative.² Over those years dispensing doctors actually saved the government £33m (table); this amounts to an average of 23p per item dispensed. A secondary factor that gives the lie to the supposition is that there is a constant downward pressure on all prescribing (and therefore dispensing) by general practitioners and any such "pocket lining" would be quickly picked up.

The Dispensing Doctors' Association has asked Baroness Cumberlege for an explanation of her remark.

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1 Warden J. Dispensing with doctors? *BMJ* 1992;304:1530. (13 June.)
2 Prescription Pricing Authority. *Annual report*. London: PPA, 1985-91.

Medical abortion

EDITOR,—In the correspondence about the cost effectiveness of medical abortion both the cost of the drug and the facilities and staff required to deliver the service may have been overestimated.^{1,2} The cost of the drugs in the United Kingdom—about £65—is based on the combination of 600 mg mifepristone (£44) and 1 mg gemeprost vaginal pessary (£21). Recent data have shown that the dose of mifepristone and gemeprost may be reduced without loss of efficacy.^{3,4} Moreover, preliminary trials have suggested that oral misoprostol may be a cheaper (about £1), safer alternative prostaglandin.⁵ If these studies are confirmed in larger trials it should be possible to reduce the cost of the drugs. The facilities and staff required to provide an effective, safe service for medical termination may also have been overestimated. On the basis of our experience in the past 10 years of nearly 1000 medical terminations in early pregnancy, we have established a protocol for a routine service entailing three outpatient visits.⁶

Mifepristone is given at the first visit after the initial outpatient consultation and counselling for termination. If the history and clinical examination confirm that the pregnancy is of less than nine weeks' gestation an ultrasound scan of the uterus is unnecessary. The second visit entails a stay of about four hours after the prostaglandin is given. We have shown that up to five women can be treated simultaneously in a sitting room with minimal nursing care. Only a minority (34%) preferred to lie down because they felt pain or nausea, or both. Most found the companionship of women in similar circumstances reassuring. Though a third follow up visit is not strictly essential for the 80% of women in whom the fetus

Annual cost of items dispensed by doctors and pharmacists, 1985-91

Year	Average cost per item less VAT (£)		Saving made by doctors per item (£)	Total saving by doctors (£m)	Potential saving had all doctors dispensed (£m)
	Doctors*	Chemists			
1985-6	4.629	4.877	0.248	5.227	82.909
1986-7	4.920	5.172	0.252	5.595	87.667
1987-8	5.288	5.552	0.264	6.256	102.544
1988-9	5.797	6.017	0.220	5.404	81.000
1989-90	6.098	6.321	0.223	5.792	85.261
1990-1	6.543	6.742	0.199	5.370	77.610
Total				33.644	516.991

*Pharmacists do not pay VAT so VAT has been deducted here to make the figures comparable.