cardinal symptoms of a pharyngeal pouch also include spontaneous regurgitation, weight loss, and dysphagia.²

Barium swallow is the principal means of diagnosing both oesophageal achalasia¹ and pharyngeal pouch. Moreover, there is a very real risk of a traumatic oesophageal perforation as a result of entering an unknown pouch, even with a flexible endoscope. Barium swallow is a simple, non-traumatic, cheap, and safe outpatient investigation suitable for most patients with suspected oesophageal pathology, and traumatic oesophageal perforation due to endoscopy in the absence of a barium swallow would be difficult to defend.

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1 Pagliero KM. Oesophageal achalasia mistaken for anorexia nervosa. *BMJ* 1992;305:583. (5 September.)

2 Bowdler DA. Pharyngeal pouches. In: Kerr AG, ed. *Scott-Brown's otolaryngology*. Vol 5. 5th ed. Oxford: Butterworth Heinemann, 1987:264-83.

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Partners in practice

EDITOR,—I was concerned to note the omission of the pharmacist from the spectrum of carers portrayed by Constance Martin, although she seemed to consider every possible lay and professional carer who might come into contact with the patient.¹ I am a pharmacist employed as a lecturer within a university department of general practice and one of my research interests concerns the interface of pharmacists and general practitioners and their shared role in the effective and appropriate use of medicines. Recent government publications have endorsed an extended role for the community pharmacist, which would include among other things greater patient involvement and interdisciplinary collaboration with general practitioners.^{2,3}

In the hospital setting the pharmacist plays an important and established part in decisions relating to the pharmaceutical care of patients. There is also a definite and equivalent place for the pharmacist in the primary health care team, and this should be acknowledged by the other professions so that the particular skills of the profession are utilised to the benefit of the rest of the team, and most importantly the patient.

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1 Martin C. Partners in practice: attached, detached, or new recruits? *BMJ* 1992;305:348-50. (8 August.)

2 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health*. London: HMSO, 1987. (Cmd 249.)

3 Department of Health Joint Working Party. *Pharmaceutical care: the future for community pharmacy*. London: Royal Pharmaceutical Society, 1992.

Delays in thrombolysis

EDITOR,—J S Birkhead's review of delays to thrombolysis in patients with suspected myocardial infarction¹ raises some important issues with regard to the effective delivery of modern coronary care.

Firstly, now that the components of delay are reasonably well understood it is time to introduce systematic monitoring of the administration of these drugs. This could most easily be achieved by incorporating delay monitoring into the service specification of contracts for coronary care between purchasing authorities and their provider units. Since only a portion of the total delay is the direct responsibility of the hospital service this would

have to be broken down into delay between onset of symptoms and calling for help; delay between calling for help and arriving at hospital; and, finally, "door to needle" time. Each component of delay could then be tackled separately and the results of intervention continuously monitored.

Secondly, Birkhead expresses some concern that wider use of self referral to hospital through the ambulance service may lead to inappropriate calls. This is clearly a concern, but as over half of myocardial infarct victims already have established coronary heart disease² this problem could be minimised by concentrating advice on self referral to people known to have heart disease or at high risk in the first instance.

Thirdly, the data presented in the review suggest that only 58% of patients later shown to have myocardial infarction received thrombolysis. The reasons for not giving thrombolytic drugs have been presented in a recent study from Edinburgh.³ These were non-diagnostic electrocardiogram (46%); over six hours' delay since onset of symptoms (18%); peptic ulcer (5%); and "miscellaneous" (31%). Since thrombolytics have such a dramatic effect on mortality an expansion in coverage as well as a reduction in delay is important. Now that delays in thrombolysis have been analysed perhaps it is time for clarification of a feasible target for thrombolytic coverage in patients with myocardial infarction.

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1 Birkhead JS. Time delays in provision of thrombolytic treatment in six district hospitals. *BMJ* 1992;305:445-8.

2 Armstrong A, Duncan B, Oliver MF, Julian DG, Donald KW, Fulton M, et al. Natural history of acute coronary attacks. *Br Heart J* 1972;34:67-80.

3 Pell CH, Miller HC, Robertson CE, Fox KAA. Effect of "fast track" admission for acute myocardial infarction on delay to thrombolysis. *BMJ* 1992;304:83-6.

False positive salivary HIV test

EDITOR,—When asked to do an HIV antibody test for insurance, employment, or other, similar purposes I counsel the patient before sending the blood sample to my local public health laboratory. On receiving the result I give a copy of the report to my client and it is up to him or her to use this information in whatever way he or she chooses. I have always refused to send a specimen to a laboratory if I am not going to be informed of the outcome.

Recently a local general practitioner asked me to see a patient; he had been told that the patient was apparently HIV positive. The man required an HIV test for insurance purposes. After counselling by the general practitioner he was asked to produce a saliva specimen, which was dispatched to a named laboratory in a kit supplied by the insurance company. The patient subsequently received a verbal message to see his general practitioner, who had been informed of his HIV status. The insurance company suggested that the man should be given a blood test to check the result of the salivary test. There was nothing in the man's history to suggest that he had been at risk, and the result of the serological test for HIV antibodies was, as expected, negative.

Several disturbing points arise from this case. Firstly, this man, who was happily married with a family, suffered 48 hours of considerable distress, which in someone less well balanced could have led to attempted or even successful suicide. Secondly, although the insurance company assured the general practitioner that all information relating to the patient's original positive HIV test result would be eliminated from the records, what guarantee has the patient that this in fact has been done? Finally, I understand that the salivary test

for HIV was developed as an epidemiological tool and in no way was to be a substitute for the serological test. The apparent false positive result of the salivary test must cast doubt on the quality control procedures of the laboratory that performed that inappropriate test.

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Preparing for a foreign fellow

EDITOR,—Lindsay J Smith and Catherine Marraffa's advice to those preparing for a foreign fellow requires expansion to cater for the position of overseas qualified doctors who are not registered with the General Medical Council before they arrive in Britain.¹ Not all primary medical degrees granted overseas are accepted by the council for registration. Many more degrees are accepted for limited than for full registration, and the range of employment open to doctors holding such degrees is limited accordingly.

The granting of limited registration is in addition subject to several statutory conditions, and scrutinising applications is a complex task that takes time. The council advises all overseas qualified doctors planning to come to Britain to get in touch with the council's overseas registration division at least six months before their intended arrival to obtain advice about their eligibility.

Doctors who are eligible for registration must submit the originals of their degrees and other certificates: the council does not accept any kind of copy, including the notarised copies to which Smith and Marraffa refer.

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1 Smith LJ, Morraffa C. How to prepare for a foreign fellow. *BMJ* 1992;305:460-1. (22 August.)

Psychiatrists in the new NHS

EDITOR,—By April 1993 there will be about 6500 fundholding general practitioners. From the same date, general practitioner fundholders will purchase for their patients all community and outpatient mental health services.¹ What will this mean for psychiatry?

To predict how fundholding general practitioners might wield these new powers we need to look at how they use and what they say about mental health services now. General practitioners increasingly refer patients to the growing numbers of community psychiatric nurses, clinical psychologists, and counsellors, and when these options are available the number of referrals to psychiatry services are almost certain to fall.²

Are these other professionals as effective as psychiatrists? A recently published randomised trial of care for depressed patients in primary care found counselling (in this case by a social worker) to be significantly more effective clinically, more likely to be endorsed by patients, and as cost effective as treatment by a psychiatrist.³ Other studies have shown other specialist or paramedical staff to be at least as effective as psychiatrists.⁴

The challenge to psychiatry posed by the growth of other professions is not new. Ten years ago Michael Shepherd warned that "the psychiatrist must now be prepared to define his own function if he is to justify his status."⁵ General practitioner fundholding and the internal market, however, are crucial new factors in the equation. If the NHS reforms continue in the intended direction there will be a large transfer of resources and power from

secondary to primary care. Psychiatrists must realise this and start taking the criticisms of their clients and clients to be, the general practitioners in their area, more seriously than they do at present.

This question needs to be addressed: if funding general practitioners are given the choice between a hospital oriented psychiatry service and other, equally effective, services that may be cheaper and are more flexible, how long before they start putting psychiatrists out of work?

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- 1 Department of Health. Press release H92/242, 23 July 1992.
- 2 Wilkinson G. I don't want you to see a psychiatrist. *BMJ* 1988;297:1144-5.
- 3 Scott AIF, Freeman PL. Edinburgh primary care and depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;304:883-7.
- 4 Balestrieri M, Williams P, Wilkinson G. Specialist mental health treatment in general practice: a meta-analysis. *Psychol Med* 1988;18:711-7.
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Reaccrediting general practice

EDITOR,—I believe that Denis Pereira Gray is wrong in his assumption that the profession has given a mandate to its leaders regarding re-accreditation. It is my opinion that he has falsely misinterpreted certain answers on the questionnaire *Your Choices for the Future*. The fact that two thirds of general practitioners disagreed with the statement "Once a GP has acquired a basic level of competence no further form of reappraisal is necessary during the rest of his/her active professional life" does not mean that two thirds of general practitioner's want a formal system of reaccreditation. Nor do general practitioner's actively want peer review; they simply want re-examination less.

Our performance as general practitioners is already more closely monitored than are most other branches of our profession or most people in other professions. We are all ultimately accountable to the General Medical Council for our professional conduct and standards.

We are accountable to the family health services authority, which monitors our standards (hours of availability, competence to practice minor surgery, paediatric surveillance, etc); they monitor our practice premises and our attendance at continuing education course to the equivalent of five full days a year. If we fail to meet standards, patients may have recourse to the law and, unique to general practice, yet another tier of monitoring by the family health services authority's complaints procedure. In most areas medical audit advisory groups visit practices, encouraging audit and reporting back to the family health services authority.

Those who are trainers have regular reapproval visits, written assessments by the trainee, and visits from trainers and occasionally the Joint Committee for Postgraduate Training. Pereira Gray puts forward the joint committee as a model of a reaccreditation system. Many colleagues have variously described its visits as being unpleasant, unhelpful, and unwelcome.

Finally, we are monitored by our patients, who consult the general practitioner who most suits their needs.

It is my opinion that we are already the most carefully scrutinised and monitored of all professions. Instead of fashioning yet more sticks with which to beat ourselves, we should wait for dentists, lawyers, accountants, etc, to catch us up. I believe that the majority of general practitioners do not want reaccreditation and that certain leading lights of the royal college are simply using this as a

means of gaining more control over this profession. I urge my colleagues to reject compulsory re-accreditation.

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- 1 Pereira Gray D. Reaccrediting general practice. *BMJ* 1992;305:488-9. (29 August.)

EDITOR,—There are three points I would like to make on Denis Pereira Gray's article on re-accreditation.¹

Reaccreditation in the wrong hands would be a perfect opportunity for an aggressive, well connected minority to impose its view of general practice on the majority. The new contract was a perfect example of this. The whole profession would have to be consulted, rather than leaving it to members of the General Medical Services Committee, the Royal College of General Practitioners, and university postgraduate departments.

Any implication of unsatisfactory performance would be used by the Department of Health as a financial exercise. Look at "health promotion"—an idea of dubious clinical value, but a perfect vehicle for cutting costs.

The clear message contained in *Your Choices for the Future* was not the desire for reaccreditation but the need to change our absurd system of working.

What most of us need are conditions of service that enable us to practice our skills efficiently, not more sources of anxiety. Unfortunately, we are likely to get reaccreditation before reorganisation.

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- 1 Pereira Gray D. Reaccrediting general practice. *BMJ* 1992;305:488-9. (29 August.)

The Health of the Nation

EDITOR,—There are statistical difficulties (owing to the small numbers involved) inherent in the direct translation to district level of many of the targets contained in *The Health of the Nation*.¹ Nevertheless, because the data used to calculate the rates quoted are available routinely, districts may use the white paper indicators in descriptions of the health status of their populations. This is not, however, straightforward for some of the indicators—for example, in calculating teenage conception rates.

Using routine birth and abortion statistics, the calculation of the national numerator in *The Health of the Nation* is based on the assumption that, on average, a pregnancy lasts 38 weeks (Office of Population Censuses and Surveys, personal communication). Age of the mother at conception is calculated by subtraction from the date of birth and comparison with the mother's date of birth. These data are available for regions, but not at district level, where information is routinely presented only by age of the woman at the time of birth or termination of pregnancy. Simply adding together the number of births and abortions for those aged under 16 substantially underestimates the number of conceptions, since many of those who conceive aged 15 will be 16 when they give birth. An approximation to the true number of conceptions may be obtained by including, in addition to all those who gave birth aged under 16, 73% (38/52) of those who gave birth aged 16. The other difficulty is in calculating the denominator (girls aged 13-15 years) where, at district level, another approximation must be used—namely, application of the proportion of girls aged 13-15 nationally to the district estimate of population in five year age bands.

We hope that this information will be helpful to

others who are involved in developing district responses to *The Health of the Nation*. We should like to strenuously endorse John Gabbay's plea for national initiatives to aid the development of appropriate local target measures for *The Health of the Nation* priority areas and the epidemiological information systems to go with them.² In the meantime, to prevent a laborious reinvention of the wheel the routine availability at district level of the rates derived by the Office of Population Censuses and Surveys that were used in the white paper would be most helpful.

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- 1 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986).
- 2 Gabbay J. The health of the nation: seize the opportunity. *BMJ* 1992;305:129-130. (18 July.)

AIDS: guidelines for barbers

EDITOR,—In answering a question about the risks of acquiring infections from barbers' equipment Alan Scott suggests that there is a theoretical risk of transmission of bloodborne infection but no documented episodes.¹ There has been at least one report, however, of transmission of hepatitis B virus associated with sharing razors within a household² and several documented cases of hepatitis B infection after parenteral exposure during acupuncture and tattooing.

Scott quotes a booklet published by the Department of Health and Social Security which recommended that hairdressers and barbers should use razors with disposable blades and change the blade for every customer.³ My experience suggests that this recommendation has not been taken up and barbers do not change the blade between customers. *The Health of the Nation* identified HIV and AIDS as one of five key areas for action and prevention⁴; if an effort is to be made in this we should not only campaign for safer sex and to prevent needle sharing among drug addicts, but other types of percutaneous exposure should be targeted. The risk from malpractice in barbers' shops may be modest, but tightening up practice would be easy and is long overdue.

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- 1 Scott A. Any questions. *BMJ* 1992;305:566. (5 September.)
- 2 Goh KT, Ding JL, Monteiro EH, Oon CJ. Hepatitis B infection in households of acute cases. *J Epidemiol Community Health* 1985;39:123-8.
- 3 Department of Health and Social Security. *AIDS: guidelines for hairdressers and barbers*. London: DHSS, 1987.
- 4 Department of Health. *The health of the nation*. London: HMSO, 1992.

Corrections

Oesophageal atresia mistaken for anorexia nervosa

Owing to an editorial error the title given to the letters by James McSherry and by K M Pagliero (5 September, p 583) was incorrect. The title should have been "Oesophageal achalasia mistaken for anorexia nervosa."

Cardiac rehabilitation programmes

In the third paragraph of this letter by J T Scanlon and S Godfrey (12 September, pp 649-50) the number of women who underwent an exercise test should have been 19% (not 9%); this was a printers' error.