and fertilisation rate ($p=0.001$) but not for indication ($p=0.08$) or age ($p=0.9$). The group who stopped treatment had a higher rate of total fertilisation failure, a lower fertilisation rate, and a generally more unfavourable indication for in vitro fertilisation. These results indicate that the assumption of the life table method is not met because patients who decide to stop treatment are likely to have less chance of conceiving by in vitro fertilisation than patients who continue.

Few studies giving cumulative pregnancy rates after several cycles of in vitro fertilisation evaluate possible selection bias in the couples who continue treatment. To avoid too high expectations people should be aware of the possibility of such selection, particularly in a study with the objective "to provide reliable prognostic information for couples seeking assisted conception."

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Reaccrediting general practice

EDITOR,—John Russell reports a small number of problems with assessment visits in general practice about which he has been informed anecdotally.¹ Against this, however, must be set the view of over 24 000 general practitioners, who responded "Disagree or strongly disagree" to the statement "There is no need for the profession to consider the possibility of a system of professional accreditation and re-accreditation at the present time" as follows: general practitioners with "no involvement with training"—49.1%; general practitioners with "training provided in the practice"—60.9%; general practitioners who "provide training personally"—70.1%.² It is therefore still logical to conclude that those general practitioners who have had personal experience of the trainer system, which involves about a quarter of all general practices in Britain, are more in favour of reaccreditation than those who have not.

Chris Nancollas emphasises the importance of consultation.³ The General Medical Services Committee represents all general practitioners in the NHS and regularly communicates with all local medical committees in the country. Similarly, the Royal College of General Practitioners is committed to its local faculties, which cover the whole of Britain.⁴

Developments in medicine worldwide have placed greater emphasis on continuing education and assessment or reaccreditation, or both, for all health professionals. It seems wise for the medical profession to continue to work on this, and it is encouraging that both Russell and Nancollas also believe that assessment of general practitioners through peer review is preferable to other methods, such as re-examination.

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Guidance on guidelines

EDITOR,—Andrew Haines and Gene Feder's editorial on clinical guidelines draws attention to issues that need to be resolved if Britain is to avoid the American experience of producing thousands of guidelines of unproved efficacy.¹ Many of these issues were raised last year at a conference to assess the progress made in developing guidelines in Britain.^{2,3} Three crucial issues surfaced: how guidelines can be produced and owned locally but not be perceived as being inferior to guidelines published by national bodies; how to ensure that they are updated regularly; and how to ensure their effective dissemination and use.

A national "clearing house" may seem to be an attractive means of collating and disseminating information. The experience of the King's Fund Centre in setting up a centralised system for collating details of good practice in medical audit, however, suggests that this process in isolation is of limited value (personal communication). The research and development initiative provides an alternative model, in which the provision is organised at a regional level.⁴

Guidelines are an important component of the development of explicit standards of care and thus are intimately connected with medical audit. It may be opportune, therefore, to integrate the "guideline industry" with the medical audit initiative; a strong medical audit structure already exists at regional level. In South West Thames, on the basis of 13 years' experience of producing hospital guidelines, we have established a treatment guidelines centre at St George's Hospital Medical School. This unit will disseminate information on national and local guidelines and also provide a publishing service for individual units. Its aim is to facilitate the development of local guidelines rather than to standardise practice across the region.

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The death penalty

EDITOR,—In his editorial Richard J Bonnie mentions a recommendation of a BMA working party that certification of death should always take place away from the site of an execution.¹

That is not enough. The certifying doctor has to be removed from the execution with regard to both place and time (so as not to monitor the execution by, for example, electronically transmitted electrocardiography). Certification should be issued for medicolegal purposes only at a time and place where there is no longer any non-medical doubt about death having occurred.

The reason for this requirement is the sad fact that doctors are probably always present at executions (in the United States and elsewhere). Their "certification of death" amounts in many cases to active participation in the execution itself (monitoring heartbeats, etc and then accordingly ordering more voltage or more intravenous poison if deemed necessary) until they can certify that death has occurred and the executional process can be stopped, thereby making them de facto the chief executioners.

The request for certification was meant to be for the issuing of a medicolegal (written) statement

that death had irrevocably occurred at some earlier time. Instead, many doctors have twisted "certification" into meaning "certain making," from the original Latin meaning of the word *certificare*, thereby allowing them the actions mentioned above.

The Council of Judicial and Ethical Affairs of the American Medical Association is working on a new and stricter resolution, hopefully much along the lines of the resolution adopted by the Nordic medical associations in 1986, which in part reads: "For a physician to prepare, administer or monitor any procedure with a view to injuring a human being or to train others to do so would be a perversion of medical knowledge and skill and of the physician's responsibility to and role in society. Thus the medical associations of the Nordic countries... declare it indefensible for any physician to participate in any act connected to and necessary for the administration of capital punishment."

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1 Bonnie RJ. The death penalty. *BMJ* 1992;305:381-2. (15 August.)

Health checks for people over 75

EDITOR,—We were disturbed to read about the inadequacies in the system of annual health checks for people over 75, especially those relating to the detection of dementia.^{1,2} The shortcomings included lack of follow up of people not responding to the offer of a health check, the fact that inexperienced nurses performed the assessments, and a lack of national guidelines.

Detecting early dementia is important as it probably lessens the need for crisis intervention for patients' and relatives' support and because treatments likely to be available soon will depend on early diagnosis for best effect. Regular screening of elderly people is potentially useful for detecting dementia. We recently canvassed 37 local practices to examine what cognitive assessment was carried out in their checks of people over 75.

We received replies from 26 of the 37 practices (70%): three were completed by general practitioners, who indicated that they did most of their practice's assessments, and the rest by practice nurses. All 26 respondents reported assessing mental function, 16 informally and 10 formally. Of those who assessed it formally, four used a test and six used specific questions, one going on to use a test if this was indicated. Three different tests were being used, most commonly the abbreviated mental test score.³ This was usually provided by the Alzheimer's Disease Society. In an open question only three of the respondents who formally tested cognition indicated that the presence of physical or sensory problems affected their interpretation of performance. Five respondents spontaneously requested advice regarding the use of suitable tests.

Detection of dementia is unlikely to be achieved effectively by informal assessment by untrained staff. Screening instruments would enhance detection if training was given in their administration and interpretation. The abbreviated mental test score is appropriate as it is short and is effective at detecting dementia⁴ and at discriminating between organic and functional illness,⁵ which is probably important. Patients who perform poorly or whose test score has decreased should subsequently be assessed by their general practitioner. Cognitive screening of people over 75 in an average practice of 2000 people would produce around 17 people needing medical assessment,⁶ though in the second year of a screening programme the number should be lower.

The current lack of national guidance and uniformity of assessment is evident from our survey, and it was interesting that advice about cognitive tests had usually been provided by a voluntary body rather than come from within the NHS.

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Merit awards

EDITOR,—In discussing merit awards John Appleby states that over half the consultants in pathology receive awards.¹ This figure is inaccurate but was presumably derived from the category of "general pathology" in which, in 1990, exactly half the consultants received merit awards. However, in this group, only six consultants throughout the country were eligible.

This is because nowadays most consultants practise in one of the four main subspecialties, for which the current percentages of award holders is as follows: haematology 35%; histopathology 31%; medical microbiology 36%; chemical pathology 34%.

The national percentage for all specialties is 35%.

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1 Appleby J. Merit awards attacked by economists. *BMJ* 1992; 305:852-3. (10 October.)

Caste discrimination in India

EDITOR,—Linda Beecham reports that the Commission for Racial Equality is to investigate possible discrimination against ethnic minorities in the appointment of consultants.¹ A parallel problem should be investigated in India—namely, discrimination against scheduled castes and scheduled tribes, which is unique to India. The phenomenon is akin to racial discrimination because caste is decided by birth.

Proportions of members of scheduled castes and scheduled tribes at undergraduate, postgraduate, registrar, and consultant levels in India and All-India Institute

Level*	Quota (%) constitutionally allotted ^a		Admissions or appointments to All-India Institute against allotted quota (%)	
	Scheduled castes	Scheduled tribes	Scheduled castes	Scheduled tribes
Undergraduate	15	7.5	100	100
Postgraduate	15	7.5	100	100
Registrar	15	7.5	95	94
Consultant	15	7.5	38	8

*Admission or appointment by nationwide open competition or interview.

Contrary to C Mbubaegbu's belief,² I think that representation at registrar level is of no help for consultant appointment. Statistics from the All-India Institute of Medical Sciences, a leading medical centre directly governed by act of parliament, smack strongly of discrimination against members of scheduled castes and scheduled tribes at consultant level (table). Although the Constitution of Union of India provides special provisions for adequate representation of scheduled castes and scheduled tribes in all government services,³ the first scheduled caste consultant was appointed 28 years after the institute's establishment in 1956, and scheduled tribes were not represented at consultant level until 1990. Beecham reports that several doctors have been successful in complaints to industrial tribunals,⁴ but proving that a person has been discriminated against in violation of the constitution of India is almost impossible. The court of law tends to uphold the selection committee's verdict of non-suitability of the candidate rather than entertain the plea of discrimination on grounds of caste.

If caste discrimination is not the reason, how does one explain the paradox (table) that people who have been found suitable at undergraduate, postgraduate, and registrar levels are suddenly discovered to be unsuitable for the next grade?

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Local voices

EDITOR,—Allyson M Pollock highlights the pitfalls of undertaking public consultation as recommended in *Local Voices*.^{1,2} We used an invitation to speak at a meeting of the local branch of the British Diabetic Association as an opportunity to gather consumers' views about diabetic services. We asked the group of 34 diabetic subjects and their carers to describe their views on the strengths and weaknesses of the general practitioner, hospital, and community services; their aspirations for service developments; and the barriers they perceived to achieving these improvements. A sociodemographic profile and other relevant data relating to the group were collected by an anonymous self completion questionnaire.

Aspirations for services included improving support for carers and developing communication between hospital and primary care services "so that each knows what the other is doing." The group believed that the main barriers to achieving these developments were inadequate resources and the conflicting priorities faced by the NHS. The group had previously been subject to detailed questioning as part of a research project and made comments such as "I could hardly face going

through all that again." We now have a professional responsibility to show that our dialogue can have some effect.

Though the methodological constraints of this approach to public consultation are similar to those of surveys and of work with focus groups, the approach has the merit of allowing discussion of difficult conceptual issues without any confusion regarding representation. The general lesson is clear: the cost of provoking frustration among the public by such consultation must be balanced by a clear commitment to respond.

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Abortion in Northern Ireland

EDITOR,—On 1 June I wrote to Sir Patrick Mayhew, secretary of state for Northern Ireland, to bring to his attention the startling results of a survey in Northern Ireland on abortion released in May.¹ It showed that 79% of respondents questioned by Ulster Marketing Surveys wanted abortion legalised on health grounds, 76% on grounds of rape or incest, and 57% on grounds of severe handicap of the child if born, and substantial minorities wished to see abortion legalised on social grounds and on the request of the mother alone. Readers of Colin Francome's editorial² may be interested in the response, which was sent to me on 18 August. This made three main points: firstly, as in 1988,³ the law could be extended only if "change could command broad support amongst the people of the Province"; secondly, "it is unlikely that the results of a single opinion poll would be considered a suitable basis for new and highly controversial legislation"; and, thirdly, "to date no N Ireland MP has expressed an interest in introducing legislation to amend the law on abortion."

In successive free votes in the House of Commons Sir Patrick Mayhew has voted against abortion in a personal capacity. He voted for Mr John Corrie's restrictive bill in 1979, and again for Mr David Alton's in 1988. Clearly, therefore, no Northern Ireland MP is likely to receive any encouragement from Sir Patrick Mayhew in modernising Northern Ireland's antiquated and unpopular abortion laws.

The new purchaser-provider arrangements in the NHS may have the effect of making it more difficult for women from Northern Ireland to obtain abortions in England, as nearly 2000 do each year at present. Once the English safety valve is turned down two developments may be expected: the growth of an illegal abortion sector in Belfast and the birth of more unwanted babies to mostly very young mothers.

The 30000 Northern Irish women who have obtained legal and safe abortions in England since the Abortion Act was passed in 1967, and their doctors who in many cases refer them, constitute a powerful potential pressure group. Only once they realise their powers and exercise them with the same single minded determination as do the extremist sectarian pressure groups will there be any progress in bringing Northern Ireland's abortion laws into line with those prevailing in the rest of Europe.

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