smaller lists but enjoy similar incomes to those of practices in more prosperous areas. There is a danger that health planners may see the payments as the resources needed to provide additional staff and better premises. The provision of extra staff to meet greater health needs and adequate cost rent funding of high land and building costs are separate issues. Unless the Department of Health affirms its belief in the value of small lists in deprived areas the serious problem of recruitment of doctors to work in these areas will rapidly become a crisis.

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1 Crayford T, Shanks J, Bajekal M, Langford S. Analysis from inner London of deprivation payments based on enumeration districts rather than wards. *BMJ* 1995;311:787-8. (23 September.)

Public discussion of rationing decisions is essential

EDITOR,—David J Hunter offers an eloquent defence of "muddling through elegantly" in the cause of health care rationing or priority setting.¹ Yet in counselling against a national debate on priority setting he confuses different aspects of the priority setting process. Decisions by clinicians on whether and how to treat individual patients do not need to be open to public scrutiny and are best made implicitly. The same does not apply to decision making at the level of health authorities or government. It is here that both transparency and public debate are essential. As Rudolf Klein comments in his editorial in the same issue, other countries have shown how this can be done.²

To argue against public discussion is to run the risk of paternalism of the worst kind. Decisions on priorities for communities and whole populations involve value judgments that are too important to be left to professionals. It is all the more important, therefore, that these decisions involve as wide a set of interests as possible. The outcome may not always satisfy the experts, but this is always a risk in a democratic process.

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1 Hunter DJ. Rationing: the case for "muddling through elegantly." *BMJ* 1995;311:811. (23 September.)

2 Klein R. Priorities and rationing: pragmatism or principles? *BMJ* 1995;311:761-2. (23 September.)

Community care and general practice

Focus should be put on barriers that hinder progress

EDITOR,—In their editorial on community care and general practice David Kingdon and Sue Sumners state that the changes in community care in 1993 "seem to have had a smooth take off".¹ This depends on the perspective from which the issues are being explored.

In a study to explore the impact of the reforms of community care on general practice we contacted general practitioners from areas in the former North East Thames region who had previously responded to a questionnaire; 90% reported changing the patterns of their input to the groups of people eligible for community care.² Most of the general practitioners and representatives of social services whom we interviewed believed that clients were not being offered an increased choice in their care regimens; this was central to the aims of the

original white paper.³ Moreover, two thirds of the general practitioners thought that the needs of people with chronic mental illness were either being met badly or were not being met at all. Lastly, almost two thirds of the general practitioners rated their relationship with their local social services as neutral, bad, or non-existent.

Surely, therefore, the continuing challenge of community care is how to enhance joint working to meet patients' increasing needs within this context of poor relations between the core providers of service in the community. Perhaps face to face contact and a joint commitment to closer, more effective working would be a start, as has been suggested in a pilot project in London.^{2,4}

Recently the King's Fund has stated that general practitioners ought to be engaged in community care.⁵ On the basis of our questionnaire data and interviews with general practitioners we believe that this should be amended to "re-engaged," since many general practitioners felt ill prepared before full implementation of the reforms and yet are expected to help augment care in people's homes.

Schemes involving fundholding and joint commissioning need evaluation, but the basic requirement for health and social practitioners to work together is an essential precursor to this. The jury is still out on the overall success of the reforms—necessarily, since they form a 10 year plan. It is surely now prudent, however, to stop talking of a smooth take off and focus more on the barriers that hinder progress and devise strategies to overcome them.

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1 Kingdon D, Sumners S. Community care and general practice. *BMJ* 1995;311:823-4. (30 September.)

2 Lloyd M, Webb S, Singh S. *General practitioners and the community care reforms*. London: North Thames Regional Health Authority, 1995.

3 Department of Health. *Caring for people: community care in the next decade and beyond*. London: HMSO, 1989. (Cm 849.)

4 Tarbuck H. *Health and Social services development project*. London: City and East London Family Health Services Authority and London Borough of Tower Hamlet Social Services, 1995.

5 Robinson J. *Community care development programme: consultation document, a response from the King's Fund*. London: King's Fund, 1995.

Multidisciplinary, proactive care is needed

EDITOR,—David Kingdon and Sue Sumners highlight the potential of general practitioners to enhance the medical care of some of the most vulnerable members of society.¹ Our experience is that community care cannot be delivered by the primary health care team in isolation: it requires new working relationships with hospital consultants, community nurses, the local authority, and the independent sector. In Fitznells Manor Surgery, which is a fundholding practice with four partners and over 11 000 patients, the process has been activated by the establishment of a 13 person, multidisciplinary proactive care team representative of these liaisons. The team organises the care of vulnerable patients (mainly elderly people) and meets every two months to review key cases, ensuring that all patients in the cohort are monitored continuously. Quality of care is enhanced by assigning to each patient a key worker, who communicates the patient's progress to the team.

Kingdon and Sumners raise an important concern in general practice—namely, that community care places an increased burden on overworked general practitioners. Our proactive care team has provided considerable support for, and greatly reduced the work of, practice staff caring for vulnerable people.

Team meetings enhance awareness of the needs of patients and their carers. The cohesion generated suggests a commonality of purpose that avoids the potential counterproductivity that can arise when different services are involved and reduces the risk of mixed messages to the patient. In addition, meetings provide a forum where trade offs can be made and pragmatic options for each patient identified. The range of services that each discipline offers becomes known, and overreliance on an underresourced profession is avoided. At a time when the market may turn health professionals into competitors the proactive care team encourages people to work together.

As Kingdon and Sumners state, general practitioners are in an ideal position to develop innovative systems for providing community care, but we suggest they cannot do it alone. Seamless quality care requires the harmonisation of the wide range of disciplines needed to provide holistic care. When this is accomplished effectively, creative solutions to difficult problems may emerge that are beyond an individual professional's domain.

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Emergency contraception

Care must be taken to ascertain that woman is not already pregnant

EDITOR,—While I acknowledge that every effort should be made to reduce the rate of unwanted pregnancies in Britain, I do not believe that making emergency contraception available over the counter is the right way forward. My main concern, which Jeanette Cayley alludes to only briefly in her editorial,¹ is about women taking contraception when already pregnant. For a general practitioner prescribing emergency contraception, one of the most important aspects of the consultation is to ascertain that the woman is not already pregnant. As Cayley acknowledges, little is known about the effect of emergency contraception if pregnancy is already established. I suspect that some women who think that they may be pregnant may be tempted to take it to try to induce an early abortion.

Surely the way forward is to promote the availability of contraception in general and of emergency contraception in particular, as reducing medical control over it may lead to abuse with unknown consequences.

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1 Cayley J. Emergency contraception. *BMJ* 1995;311:762-3. (23 September.)

Use of the term is erroneous

EDITOR,—It is vital to be accurate when using words and phrases. Jeanette Cayley's editorial is entitled "emergency contraception,"¹ but contraception means "against conception"—that which prevents conception occurring. The object of using the postcoital contraceptive pill is to prevent nidation and further development of the conceptus and to procure an early chemical abortion. One cannot prevent what has already occurred, and

therefore the use of the term emergency contraception for early abortion is erroneous. According to the datasheet, "Schering PC4 is primarily aimed to prevent implantation of the fertilised ovum in the endometrium." Insertion of a foreign body such as an intrauterine contraceptive device achieves the same effect.

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Contract minimum dataset includes confidential data

EDITOR,—R Basu Roy and P Sriskandabalan are right to be concerned about the threat to the privacy of data related to AIDS,¹ but for inpatients it is already too late. Data on HIV status are included in the clinical coding that forms part of the contract minimum dataset,² together with the patient's name, address, postcode, date of birth, sex, and other information. Until April 1995 HIV positive status was coded according to the *International Classification of Diseases* (ICD), ninth revision, which specified a subsidiary code of 079.4. Since then the ICD-10 codes have been used, which expand illness related to HIV into main codes B20 through to B24. Similar levels of detail for other sexually transmissible diseases, abortions, and fertility treatment are also included in the contract minimum dataset. Even when, as is often the case, patients' names and addresses are removed from contract minimum dataset databases, intelligent querying strategies can be used to establish individuals' identities.³ It is well established that the combination of date of birth, sex, and postcode is sufficient to identify almost everyone except monozygotic twin children.

The contract minimum dataset forms the basis of trading in the reformed NHS: it is routinely passed between administrative and clerical staff as part of the contracting process. Without its exchange the internal market would probably not be able to operate, at least in its present form, but it may not be possible to reconcile this exchange with existing legislation on confidentiality of personal clinical data and therefore with the requirements of the Data Protection Act.

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1 Basu Roy R, Sriskandabalan P. NHS computer network will breach venereal disease regulations. *BMJ* 1995;311:754. (16 September.)

2 Department of Health. *Framework for information systems: the next steps*. London: HMSO, 1990:117-20.

3 Kay S, Goble CA. Protection and control of information in medical databases. *Current perspectives in health care computing* 1988. Weybridge: British Journal of Healthcare Computing, 1988:103-12.

Assessing the quality of care

Measuring the process of care is not always straightforward

EDITOR,—Huw T O Davies and Iain K Crombie identify the problems of monitoring outcomes to assess quality of care and suggest that the process of care may be easier to measure and interpret.¹ This idea seems attractive, but Davies and Crombie sensibly add two caveats. We wish to discuss these further, illustrating some of the problems with an example from stroke medicine.

Firstly, the authors state that measuring process as an indicator of quality is appropriate only for

interventions that have been shown to be effective, either in large randomised controlled trials or in meta-analyses. In their example (thrombolysis for myocardial infarction) the process is well defined and performance (that is, the proportion of patients receiving treatment and the speed with which this is given) is easily measured. But if we consider another well proved yet less well defined and generalisable intervention (stroke units^{2,3}) the measurement of process is less straightforward. Why stroke units work remains unclear (although several features, such as regular multidisciplinary team meetings, may be important⁴), and therefore it is not obvious which processes should be measured. Perhaps we could simply measure the proportion of patients managed in stroke units, but this assumes, unrealistically, that all units are uniformly effective.

The second point concerns the difficulty of defining appropriate processes for specific groups of patients and the influence of case mix on process. In myocardial infarction, thrombolysis is probably effective for most groups of patients (young and old patients, those with anterior and those with inferior infarcts, etc), provided there are no contraindications. But in other diseases patients may be considerably more heterogeneous, and thus interpretation of process becomes difficult. For example, use of antithrombotic drugs as prophylaxis is an appropriate process after an acute ischaemic stroke but not after a haemorrhagic stroke; if we measured the use of such drugs as an indicator of quality between units then interpretation would depend on case mix (that is, the ratio of ischaemic to haemorrhagic strokes), which may vary considerably (for example, in a neuroscience unit compared with a geriatric unit).

We agree that measurement of the process of care has much to commend it, and it avoids the huge problems of measuring and interpreting outcome data; but it may raise other problems of its own, particularly in diseases such as stroke.

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1 Davies HTO, Crombie IK. Assessing the quality of care. *BMJ* 1995;311:766. (23 September.)

2 Langhorne P, Williams BO, Gilchrist W, Howie K. Do stroke units save lives? *Lancet* 1993;342:395-8.

3 Stroke Unit Trialists' Collaboration. A systematic review of specialist multidisciplinary team (stroke unit) care for stroke inpatients. In: Warlow C, Van Gijn J, Sandercock P, eds. *Stroke module of the Cochrane database of systematic reviews*. London: BMJ Publishing Group, 1995.

4 Langhorne P on behalf of Stroke Unit Trialists' Collaboration. What is a stroke unit? A survey of randomised trials [abstract]. *Cerebrovascular Diseases* 1995;5:228.

Systematic methods must be used to develop review criteria

EDITOR,—We agree with Huw T O Davies and Iain K Crombie's comments about the difficulties sometimes encountered in identifying and using outcome measures for assessing the quality of care, and we too advocate the selective use of process measures.¹ This, however, begs the question of how high quality process measures should be developed.

Review criteria (audit criteria) are "systematically developed statements that can be used to assess the appropriateness of specific health care decisions, services and outcome."² They are therefore measures of aspects of care, including process. We have described a framework for the development of evidence based audit criteria,³ and we suggest that process measures should not only be based on research evidence but also have a strong influence on outcome. For example, many audits of asthma in primary care include criteria for the

routine measurement of peak flow rate or the routine use of self management plans. Unfortunately, as a measure of the quality of care neither of these is supported by strong research evidence, and their influence on outcome is not clearly established.⁴ Since priority must be given to processes that are genuinely important—for example, checking inhaler technique in asthma—Lilly Centre protocols categorise criteria as "must do" or "should do." Furthermore, audit criteria must be clear and precise and appropriate to the clinical setting.

A more general question concerns how evidence based audit criteria are developed and disseminated. This requires extensive resources. The development of valid process measures is analogous to the development of clinical guidelines, on which an extensive literature now exists. To ensure that improvements in care take place, however, it is not sufficient only to provide statements about appropriate care. The appropriateness of care must also be measured and modified when indicated. Thus attention is now beginning to be focused on review criteria.⁵

If recommendations for changes in performance are to be based on research evidence it is essential that systematic methods are used to develop review criteria.

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1 Davies HTO, Crombie IK. Assessing the quality of care. *BMJ* 1995;311:766. (23 September.)

2 Lohr M, Lohr KN, eds. *Institute of Medicine guidelines for clinical practice. From development to practice*. Washington, DC: National Academy Press, 1992.

3 Baker R, Fraser RC. Development of review criteria: linking guidelines and assessment of quality. *BMJ* 1995;311:370-3. (5 August.)

4 Grampian Asthma Study of Integrated Care (GRASSIC). Effectiveness of routine self monitoring of peak flow in patients with asthma. *BMJ* 1994;308:564-7.

5 Agency for Health Care Policy and Research. *Using clinical guidelines to evaluate quality of care*. Vol 1. Rockville: US Department of Health and Human Services, 1995. (AHCPR publication No 95-0045.)

How to get patients' consent to enter clinical trials

Reports of trials should state proportion of people who refuse to participate

EDITOR,—We agree with Elizabeth Wager and colleagues that "large proportions of patients refusing to enter studies may signal a problem with study design."¹ The proportion of refusals, however, may vary with the nature of the trial, the disease studied, and the type of treatment investigated.

We have recently been involved in a trial of anti-endotoxin treatment in meningococcal septic shock in children. Most parents who were approached about taking part wanted the possible benefit of the treatment being studied and consented. Four out of 28 parents refused, all for different reasons. One was unwilling to risk any adverse events, one could not accept the uncertainty of the trial, one was unable to make a decision while her child was critically ill, and one did not want her child "used as a guinea pig." In contrast, no parents refused to take part in observational studies of children with meningococcal disease that was not life threatening.

Investigators obtaining consent for trials of