The French paradox refers to the finding that French consumption of animal fat is near to the average of other developed countries while French mortality from coronary heart disease is only one third of the average. Comparison between countries seemed to show that the high French consumption of wine could be an explanation,⁴ but the results of Rimm *et al* now contradict this. Nevertheless, alcohol consumption per se is an implausible explanation of a national threefold risk reduction since in individuals its effect is only a 25-50% reduction in mortality from coronary heart disease.⁶

The recent paper by Hein *et al* proposed an alternative explanation for the French paradox.⁷ In Copenhagen the incidence of coronary heart disease was inversely related to alcohol consumption for men in the top fifth of the low density lipoprotein cholesterol distribution (above 5.25 mmol/l) but was only weakly related in others. Thus the incidence of coronary heart disease was about three times higher in non-drinking men with high low density lipoprotein cholesterol concentrations than in all other men. This result can, however, explain only a small part of the lower French mortality from coronary heart disease, since non-drinkers are in general a small minority (10% in the United Kingdom). It may also be a chance finding: many other studies with data on low density lipoprotein cholesterol have related coronary heart disease to alcohol consumption. None of these studies has reported differences in this relation between low density lipoprotein subgroups and this may mean that there were no differences. These studies should be reanalysed to confirm or refute the findings of Hein *et al*.

Alcohol consumption is believed to reduce the incidence of coronary heart disease partly by increasing concentrations of high density lipoprotein cholesterol. The study by Paunio *et al* in this issue (p 1200) further investigates the inverse relation between mortality from coronary heart disease and high density lipoprotein cholesterol concentrations in male Finnish smokers and supports a previous finding of an upturn in the highest group.⁸ Put differently, men with high density lipoprotein cholesterol concentrations of 1.62-1.75 mmol/l have one third the mortality from coronary heart disease of men in adjoining high density lipoprotein groups, but on the basis of

only four deaths. It would be unwise to place much credence on this result without assessments of significance⁹ in this and other studies.

The report *Sensible Drinking* based its recommendations for both men and women on the statement, "The evidence we have studied for men of all ages identifies a band of minimal mortality associated with a weekly consumption of between about 7 and 28 units a week."¹¹ This summary of the scientific evidence may disproportionately reflect two studies^{10,11} published in 1994. Other studies,¹² a preliminary quantitative overview,¹³ and a more extensive overview currently in progress suggest that the minimum mortality occurs below 21 units per week for men. This casts serious doubt on the appropriateness of the upwards revision of the sensible limits. Reliable conclusions about alcohol epidemiology require pooling of comparable analyses from all available cohort studies.

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Seriously deficient professional performance

Needs defining as that which puts the public at risk

The Medical (Professional Performance) Act, which became law last November, has given powers to the General Medical Council (GMC) to take action when it seems that a doctor's professional performance may be seriously deficient. The council has been concerned for some time about its inability to intervene when consistently poor care seems to result not from misconduct but from a doctor's inadequate knowledge and skills, and it sees the new powers as essential if it is to fulfil its duty to protect the public. There has also been external pressure for a means of addressing poor performance among doctors, and if the task had not been given to the GMC an alternative mechanism would almost certainly have been demanded.

Consultations with medical organisations, patients' representatives, and politicians before enactment of the legislation showed wide support for the proposed measure, but doctors are clearly worried that the resulting "performance procedures" could prove inquisitorial and oppressive.¹ The GMC now has the task of devising assessment procedures that are reliable, fair, and enjoy public confidence but avoid being cumbersome or onerous. This is a complex and difficult task, given the wide variation in types of

medical work and the very different skills which doctors practising in different disciplines may need.

An important principle which the GMC should establish at the outset is that the new procedures will deal only with *seriously* deficient performance. Although concerned to promote high standards of medical practice, the GMC's fundamental task is to maintain a register of doctors in whom the public may reasonably have confidence. The performance procedures must thus operate only when there are grounds for believing that a doctor's professional performance has fallen below a standard justifying such confidence, bringing into question his or her continued unrestricted registration.

The council has not, however, reached agreement on a definition of seriously deficient professional performance, and there are diverging views over the amount of detail which such a definition should contain. A detailed definition might offer clarity and objectivity, as well as some measure of protection against GMC decisions being challenged in the courts, but it would be restrictive. No definition could specify every form or category of seriously deficient performance. The adoption of one which attempted to do so might impose an unhealthy

degree of conformity on medical practice yet allow some forms of manifestly unsatisfactory performance to fall outside the scope of the procedures.

There is thus a strong argument for a broad definition of seriously deficient professional performance rooted in the concept of peer review, on which professional self regulation depends. This would parallel the definition of serious professional misconduct, which in law amounts to that which a responsible body of medical opinion considers to be serious professional misconduct. Seriously deficient professional performance might thus be considered to be a pattern of performance so deficient that, in the opinion of a responsible body of medical opinion, it places patients at risk of suffering serious harm. Such a definition would allow those assessing performance to determine in individual cases whether the alleged deficiencies do, in practice, expose patients to risk.

The task of devising assessment procedures also raises difficult questions. First is the breadth of the assessment: should it cover the whole range of knowledge, skills, and attributes which might be needed by a doctor in a particular specialty or should it focus on those which have been the subject of a complaint? What methods of assessment are appropriate? And how can the assessments be tailored to doctors in different grades or with varying responsibilities?

Internal GMC working papers initially suggested that a comprehensive assessment would be attempted using a range of techniques, including a detailed proforma for the doctor to complete, multiple choice examinations, tests of a variety of skills by simulation, review of medical records, discussion of cases, structured interviews, and discussions with colleagues and managers. The appropriateness of some of these methods was questioned at a GMC internal conference in February on grounds of both relevance and reliability. Extensive biographical data, for example, would shed little light on the doctor's current standard of practice. And many doctors who are performing poorly might none the less be able to pass multiple choice examinations set at the very basic level envisaged by the council's assessment working groups.

These difficulties highlight the fact that assessments of performance cannot be conducted in a vacuum. Assessors will need to take account of the nature of the job being done by the doctor and the responsibilities that this entails. Only then can an appropriate assessment be devised. That assessment should focus on areas of alleged deficiency and should aim to determine what has been the doctor's level of performance in the recent past, rather than his or her ability to reach some standard under test conditions. Review of medical records and practice arrangements and discussion of specific cases should thus be the principal tools. Assessors should be given discretion to match the scope and methods of their inquiry to the circumstances of each case, within agreed guidelines, rather than attempting a cumbersome and questionable overall assessment. They should, of course, be free to broaden their inquiries if evidence suggests that this would be appropriate. Above all, assessors should keep constantly in mind the criterion against which they are measuring performance—namely, whether patients are at risk of suffering serious harm.

In this process the involvement of lay people will be essential, both to bring a patient's perspective to the assessments and to ensure public confidence in the procedures, but the specialised knowledge required to assess doctors' performance makes it inevitable that the process should essentially be one of peer review. This can succeed only with the support of the medical profession as a whole—including a willingness on the part of doctors to participate in the procedure as assessors. That support will depend on an understanding that the procedures will be concerned only with serious deficiencies and that the methods of assessment will be fair and reasonable.

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Primary biliary cirrhosis: epidemiology helping the clinician

Epidemiology improves our knowledge of disease

Recent epidemiological and clinical research is changing our thinking on primary biliary cirrhosis, a chronic cholestatic liver disease probably of autoimmune origin. Until the early 1970s primary biliary cirrhosis was perceived as a disease that was rare, presented with persistent jaundice, and usually progressed to death from liver failure.¹ Epidemiological and clinical research based on both registers of cases in defined populations and, more commonly, clinical case series has transformed that picture. The disease is much commoner than was believed,^{2,4} as many as half of all patients may have no symptoms of liver disease at diagnosis,⁵ and both the onset of complications and death can be delayed by treatment with ursodeoxycholic acid⁶ and, when necessary, liver transplantation. Good clinical and health care strategies will depend on further integration of epidemiological and clinical research to provide better information on the frequency and natural course of the disease and to generate hypotheses about causation.

For both epidemiological and clinical purposes a widely accepted and validated case definition is necessary. In primary biliary cirrhosis the triad of results from liver function tests

suggesting cholestatic liver disease, the presence of antimitochondrial antibody on indirect immunofluorescence, and compatible or diagnostic liver histology provide such criteria.⁷ A possible case may be regarded as having any two of these. Recent descriptive studies using these criteria have indicated an apparent dramatic increase in the prevalence of primary biliary cirrhosis in some regions but with considerable geographical variation. This variation is not only global but also extends to adjacent, apparently similar, countries such as Denmark, where prevalence is low, and Sweden, where it is high.^{2,8,9} North east England has seen an apparent tenfold increase in prevalence over the past 20 years.^{3,4}

It is still unclear to what extent these geographical and temporal variations, seen in a few areas where data are available, are due to true variations in prevalence or to variations in case registration, diagnostic activity, access to expertise in hepatology, or even local interest in the disease. These variations are important, both clinically, for health care planning, and for research. If there are true geographical variations in prevalence then different levels of awareness and investigation are needed according to local patterns. If, however, the geographical