able extent of the lesions; the fact that "double covered" skin of the buttock was affected; the lack of lesions on habitually exposed sites; the association with profound tanning and lentiginosis in the same distribution; and the spontaneous resolution of some lesions when the patient stopped using the sunbed. Recent reports of sunbed-induced porokeratosis^{3,4} (a histologically identifiable disorder of keratinisation, which is occasionally associated with squamous cell carcinoma) support the argument that ultraviolet A sunbeds can cause discrete keratinising skin lesions.

The current concerns in this patient are itch and cosmetic, but the small risk of malignant change in actinic keratoses may be important in relatively young patients with hundreds of lesions. Interestingly, appreciable itch is a feature of the hyperkeratosis that precedes the development of tumours in mice exposed to ultraviolet A.⁵

NEIL H COX
Consultant dermatologist

Cumberland Infirmary,
Carlisle CA2 7HY

- 1 Shuttleworth D. Sunbeds and the pursuit of the year round tan. *BMJ* 1993;307:1508-9. (11 December.)
- 2 Speight EL, Dahl MGC, Farr PM. Actinic keratoses induced by use of sunbed. *BMJ* 1994;308:415. (5 February.)
- 3 Neumann RA, Knobler RM, Jurecka W, Gebhart W. Disseminated superficial actinic porokeratosis: experimental induction and exacerbation of skin lesions. *J Am Acad Dermatol* 1989;21:1182-8.
- 4 Fleischer AB Jr, Donahue MJ, Feldman SR. Tanning salon porokeratosis. *J Am Acad Dermatol* 1993;29:787-8.
- 5 Van Weelden H, van der Putte SC, Toonstra J, van der Leun JC. UVA-induced tumours in pigmented hairless mice and the carcinogenic risks of tanning with UVA. *Arch Dermatol Res* 1990;282:289-94.

Compliance in screening programmes

EDITOR,—Two recent letters^{1,2} highlight the points we were trying to make in our article on compliance as an objective of screening programmes.³ D Jenkins and colleagues argue that high compliance is the most effective method of reducing the overall incidence of cervical cancer.¹ They show that increasing compliance by 10% results in a 24% fall in the incidence of cancer. This may justify the extra costs of using the method of having fixed appointments to increase compliance. Alternatively, a screening programme could use a method of recruitment that avoids almost all non-attendance and still achieves high compliance.⁴

Julietta Patnick and Joan Austoker argue that high compliance is necessary to achieve the targets set out in *Health of the Nation*.² Such targeting can lead to less health gain for the nation rather than more.⁵ The *Health of the Nation* is beguiled by big or important health problems. A health problem that is small in terms of overall morbidity to society, such as phenylketonuria, but is effectively and cheaply treated would not be given high priority if such criteria were used. A low cost intervention that achieves only 45% compliance and consequently reduces breast cancer by 15% may be efficient. What counts is benefits relative to costs, not blind adherence to the targets in the *Health of the Nation*.

Value for money must take into account fixed costs such as equipment and the skill of staff. These are included in our analysis. We agree that such resources should not be left standing idle, which they are when the method of having fixed appointments is used. We proposed a solution: first use a technique of recruitment that is not associated with substantial non-attendance and then use the screening slots saved to screen other target populations.³

Patnick and Austoker argue that increasing compliance may be necessary for equity.² Equity for whom? The current breast screening service is clearly unfair to older women. The authors

point out that older women can request the service, but the few who do will be largely from the non-manual social groups. Using scarce resources to increase uptake among younger women may deny older women equality of access. Provision of such access may be efficient as well as equitable. By implication, Patnick and Austoker argued that equity of use for younger women is more important than equity of access for older women. On whose values is this judgment based? To us Patnick and Austoker do not justify either increasing compliance with breast screening or using compliance as an objective of screening.

DAVID TORGERSON
Research fellow
CAM DONALDSON
Deputy director

Health Economics Research Unit,
University of Aberdeen,
Aberdeen AB9 2ZD

- 1 Jenkins D, Gallivan S, Sherlaw-Johnson C. Compliance in screening programmes. *BMJ* 1994;308:652. (5 March.)
- 2 Patnick J, Austoker J. Compliance in screening programmes. *BMJ* 1994;308:652-3. (5 March.)
- 3 Torgerson DJ, Donaldson C. An economic view of high compliance as a screening objective. *BMJ* 1994;308:117-9. (8 January.)
- 4 Torgerson DJ, Garton MJ, Donaldson C, Russell IT, Reid DM. Recruitment methods for screening programmes: trial of an improved method within a regional osteoporosis study. *BMJ* 1993;307:99.
- 5 Mooney G, Healey A. Strategy full of good intentions. *BMJ* 1991;303:1119-20.

Forfeiting the right to clinical freedom?

EDITOR,—As John Warden highlights,¹ the medical profession is worried about the erosion of clinical freedom—and rightly so. In the face of the encroachment of budgetary stringency, closed formularies, higher profile management, and all the other pressures facing the health care system the professional independence of doctors is slowly ebbing away. Many people feel strongly that this is not a good thing. If taken to extremes, the reduction of the healing art to a mere technical formula will inevitably lead to a loss of impetus to extend the boundaries of medical knowledge and professional capability. But I must ask whether the medical profession's behaviour truly warrants a defence of this independence or whether standards of behaviour and practice have slipped so far that doctors have forfeited the right to clinical freedom.

The actions and attitude of some physicians have tainted the image of the profession as a whole. We are all well aware of numerous cases of poor and uncaring medical practice that are inexcusable yet never brought to book. There are too many cases of professional collusion to cover up mistakes by colleagues, some of which have made headline news but most of which remain buried. The General Medical Council has been accused of giving the impression that it spends more time dealing with adultery and such like than with medical matters and professional standards that genuinely affect the quality of care. Furthermore, medical leadership has been conspicuous by its silence in addressing these issues.

Many medical voices attack politicians, managers, bureaucrats, and civil servants for the ills facing the NHS. Doctors seem to blame virtually everyone involved in health care—except themselves. Until doctors face up to the deficiencies in their own behaviour the rampant arrogance and remoteness of a minority will continue to blight the entire profession. The inevitable result will be the imposition of even more managers to organise, supervise, and dictate practice in health care according to market forces, cost effectiveness, or whatever other management fashion or political dogma holds sway.

If the sloppy standards, unfeeling behaviour, and cavalier attitudes of the few cannot be eradicated it is uncertain whether medical practitioners will merit the privilege of retaining any appreciable clinical freedom and the status they have enjoyed in the past.

ANTHONY WALKER
Management consultant

London NW11 7HH

1 Warden J. Ministers begin a drive on effectiveness. *BMJ* 1994;308:558. (26 February.)

Vascular surgery in smokers

Smokers must be allowed to decide

EDITOR,—J T Powell and R M Greenhalgh continue the debate on whether the medical profession has a right to decide whether smokers should be entitled to bypass operations.¹ They point out that smoking is related to heart disease and to less successful bypass surgery and are therefore justified in asking "on the basis of this evidence what advice should we give?" But they are not content to advise smokers: they feel justified in advocating coercion. They state that continuing smokers "with inconvenient arterial disease which is not life or limb threatening but in whom surgery could improve the quality of life," should be denied surgery because "the operative risk and chance of bypass failure remain too high to justify surgery," although "if the disease progresses no smoker should be denied urgent surgery to prevent amputation, stroke, or death."

Findings of significant differences between smokers and non-smokers in operative risk and bypass failure do not, however, justify anything; they simply show a difference that is unlikely to have occurred by chance. Given that an operation could improve the quality of life, it is smokers who should decide, on the basis of the available information, whether they want to proceed: it is their life. Moreover, the authors refer to a study that showed that one year after peripheral arterial bypass surgery the patency of femoropopliteal vein grafts was 63% in continuing smokers compared with 84% in non-smokers—but this still constitutes the majority. Furthermore, the recommendation that, until their condition becomes critical, smokers should be exposed to an increased risk of amputation, stroke, or death when they assert their legal right to carry on smoking is incredulous and disturbing; so is the declaration that "sometimes the patient needs a nasty shock before heeding advice to stop smoking," which followed an appreciation of the numbers of smokers who stop smoking after myocardial infarction and resection of the lung for cancer.

How much longer is society prepared to let members of the medical profession take it on themselves to decide who gets treatment? Society funds a national health service that is supposed to be there for all. Discrimination against smokers undermines this; if it goes unchallenged, which group is next?

JULIE DAWSON
Researcher

Liverpool Public Health Observatory,
Liverpool University
Liverpool L69 3BX

1 Powell JT, Greenhalgh RM. Arterial bypass surgery and smokers. *BMJ* 1994;308:607-8. (5 March.)

Systemic review of studies is needed

EDITOR,—J T Powell and R M Greenhalgh suggest discriminating against patients on the basis of their smoking status.¹ Although they would not withhold lifesaving or limb saving surgery, they advocate bargaining with patients and offering