test whose results are of no interest to them. It is definitely naive to expect so nowadays, but it may not have been naive 50 years ago, and this uncertainty means that Carlsen *et al* "have no case."

My objections are logically sufficient to invalidate the conclusions of Carlsen *et al*, but I also think that an alternative explanation applies. Their table lists the studies they reviewed and includes the numbers of men in each. Of the total of 14 947 men, 11 225 or 75%, lived in west European countries (including Sweden and Finland) and the United States. In the past 50 years in all of these countries there has been a major cultural development—the so-called sexual revolution. Sexual freedom has become an important part of personal emancipation in Western societies, and the taboo on masturbation has almost completely been lifted. Carlsen *et al* have not found an alarming biological phenomenon, but they have found a remarkable cultural phenomenon.

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1 Carlsen E, Giwercman A, Keiding N, Skakkeboek NE. Evidence for decreasing quality of semen during past 50 years. *BMJ* 1992;305:609-13.

How to build a better manager

Consider audit

EDITOR,—There is a delicious irony about the letter from Anthony Walker, a management consultant, implying that loss of clinical freedom will be the deserved consequence of the arrogance and failings of a minority of physicians.¹ I suggest that another shibboleth—"management prerogative"—is a more appropriate target for criticism in the current climate. Has Walker audited the results of his profession's activities on the welfare of people working in organisations? Does he "arrogantly" base his practice on the premises of the functionalist paradigm alone,² or has he yet incorporated the insights derived from critical theory? My point is that even the simplicities of management are open to radically differing views on what constitutes acceptable practice.

Should Walker wish to know the damaging effects of organisational change on the morale and commitment of working people then enlightenment is available.⁴ Given that the exercise of managerial prerogative has a greater potential for harm than the exercise of clinical freedom, what structural mechanisms are in place to weed out unreflective management consultants? If Walker can conceive a viable model the clinicians may gratefully use it.

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2 Burrell G, Morgan G. *Sociological paradigms and organizational analysis*. Aldershot: Gower, 1979.

3 Alvesson M, Willmott H, eds. *Critical management studies*. London: Sage, 1992.

4 Baldwin CD. Employee commitment in a government department during a time of change. Newcastle upon Tyne: University of Newcastle upon Tyne, 1993. (Unpublished MA dissertation.)

Consider training

EDITOR,—The senior managers of the National Association of Health Authorities and Trusts call for more training for general practitioners.¹ But what of managers? Do they need more training as well? Don't the multimillion pound disasters in Wessex and West Midlands imply an urgent need for more training, or at least for some training?

It might be illuminating to learn how many NHS

managers have any formal training and qualifications in management. How many hold the diploma in management studies or have a degree in management: an MBA (master in business administration) or an MSC (master of science) in management?

The National Association of Health Authorities and Trusts calls for principals in general practice to have their training increased to five years—which, with the five year undergraduate course, means 10 years in all—with the obligatory higher degree of MRCP. What would the association regard as the first and postgraduate qualification and training as the minimum for the chief executive of an NHS trust or a health authority?

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1 Court C. NAHAT calls for more GP training. *BMJ* 1994;308:877. (2 April.)

Genesis of apoptosis

EDITOR,—John Goldman's review of the BBC2 *Horizon* programme "Death Wish" salutes Andrew Wyllie and Alastair Currie for the discovery of apoptosis or programmed cell death but makes no mention of John Kerr of Brisbane.¹ The original article on apoptosis, published in the *British Journal of Cancer* in 1972, was written by Kerr and Wyllie and Currie.² Kerr had initially described this process of cell death and called it shrinkage necrosis on morphological grounds.^{3,4} He appreciated that it could be initiated by a range of noxious agents as well as occurring in both pathological and physiological processes. The 1972 paper builds on his earlier work.

Alastair Currie met John Kerr in Brisbane while Currie was at the University of Queensland as a visiting professor. He became interested in Kerr's observations and invited him to spend a sabbatical period with him in Aberdeen. Back in Aberdeen, Currie also invited Andrew Wyllie, his PhD student, to join him and Kerr in carrying out further studies on what they eventually called apoptosis. The term "apoptosis" was suggested by Professor James Cormack, of the Department of Greek in the University of Aberdeen, for this unique pattern of cell death.

I write this in the interests of historical accuracy and so that recognition is given to John Kerr for his seminal observations.

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1 Goldman J. Genes that fail in their duty? *BMJ* 1994;308:421. (5 February.)

2 Kerr JFR, Wyllie AH, Currie AR. Apoptosis: a basic biological phenomenon with wide ranging implications in tissue kinetics. *Br J Cancer* 1972;26:239-57.

3 Kerr JFR. A histochemical study of hypertrophy and ischaemic injury of rat liver with special reference to changes in lysosomes. *Journal of Pathology and Bacteriology* 1965;90:419-35.

4 Kerr JFR. Shrinkage necrosis: a distinct mode of cellular death. *J Pathol* 1971;105:13-20.

BPA's response to Clothier inquiry

EDITOR,—It is now 10 months since the two paediatricians in Grantham, Drs Nelson Porter and Charith Nanayakkara, were made redundant after the conviction of Beverly Allitt for the murder of four children under their care. Both are appealing to the secretary of state for health under paragraph 190 of the terms and conditions of service for hospital and dental staff. The British

Paediatric Association is concerned to ensure that its views are known.

Soon after the suspension of Drs Porter and Nanayakkara a small committee was established at the request of the British Paediatric Association's council to produce a submission to the Clothier inquiry. This group included a paediatrician, who is Trent's regional representative on the council; another member of the council, who is a paediatrician working in a unit comparable in size and staffing to Grantham; and me. The British Paediatric Association's submission to the Clothier inquiry included the following paragraph: "From the information presently available it appears that the Grantham paediatricians' standard of clinical practice was comparable with that of paediatricians elsewhere. This was also the conclusion of the regional adviser in paediatrics and of the Trent region's own internal inquiry. It is probable that many paediatricians would have had similar difficulty in recognising the criminal acts which occurred in Grantham."

Unfortunately, the report of the Clothier inquiry made no reference to this submission.¹ As soon as the Clothier inquiry was published the British Paediatric Association produced a response, dated 16 February 1994, which was sent to the secretary of state for health and is generally available. In our response we emphasised that the Grantham incident was recognised and addressed within three months and a conviction followed, where the two reported similar incidents from North America took much longer to detect, resulted in many more deaths, and did not lead to a conviction for murder. We also pointed out that the Clothier inquiry did not have advice from a paediatrician working in a unit of similar size or with similar staffing constraints to those in Grantham. We went on to refer to the joint letter from Drs Porter and Nanayakkara (1 October 1990) to the regional medical officer and district managers pleading for additional medical staff to provide a safety net, in which they warned prophetically, "we do not think it is advisable to wait until a disaster strikes." Our response to the Allitt inquiry concluded that "in the view of the BPA the report's criticisms of the nurses and doctors working with the children in this environment were unjustly harsh."

The matter of Drs Porter and Nanayakkara's redundancy is a contractual issue for which the British Medical Association is responsible; it is clear that it will fight the principle hard, fearing that a precedent may otherwise be set. The British Paediatric Association does not think that either doctors should be without a job, on the basis of the Clothier inquiry's findings and the views of those paediatricians who have detailed knowledge of the events.

Copies of the British Paediatric Association's response to the Allitt inquiry are available from the association's office.

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1 Dyer C. Inquiry into serial killer criticises hospital's response. *BMJ* 1994;308:491. (19 February.)

Out of hours consultations

EDITOR,—In her paper on out of hours consultations with general practitioners Lesley Hallam laments the lack of data.¹ With regard to the demand for out of hours consultations she states that "studies are generally restricted to individual practices or small areas." We wish to summarise our data on this issue, which were not available in time for her study.^{2,4}

We combined three surveys of satisfaction, which were all done with the same instrument between November 1991 and August 1992 in large areas (sample sizes and response rates in paren-

	Age (years)		Sex		Marital status		Car ownership			Housing		Age at which left school (years)	
	<45	≥45	Male	Female	Married	Other	None	1	≥2	Owner	Tenant	<17	≥17
<i>Have you ever tried to contact the doctor out of hours?</i>													
Yes	50.7	45.7	44.5	50.8	51.9	38.9	46.6	47.5	50.4	50.5	47.5	47.7	49.1
No	49.3	54.3***	55.5	49.2***	48.1	61.1***	53.4	52.5	49.6	49.5	52.5	52.3	50.9
No of respondents	3528	3689	3077	4140	5019	2110	1261	3493	2294	5005	1300	4848	2369
<i>What happens generally?</i>													
See own doctor or partner	46.3	66.2	59.6	53.6	55.2	57.7	62.1	56.9	51.0	55.1	60.1	59.6	48.7
See another doctor	24.3	15.1	18.8	20.5	20.1	19.3	20.2	19.9	19.7	19.6	22.0	19.9	19.6
Get telephone advice	12.0	4.5	7.1	9.1	8.8	7.1	5.5	8.2	10.2	8.5	6.8	6.7	11.6
Don't know	11.6	10.4	10.0	11.6	10.8	11.7	8.3	10.3	13.4	11.8	6.8	9.4	14.1
Other	5.9	3.9***	4.5	5.2	5.1	4.1	3.9	4.6	5.8***	5.0	4.4*	4.4	6.0
No of respondents	1673	1593	1306	1960	2444	776	565	1544	1093	2363	592	2180	1086
<i>What happened the last time?</i>													
Saw own doctor or partner	38.3	57.8	49.3	46.8	46.9	51.1	54.6	48.8	43.1	47.3	50.7	49.6	44.3
Saw another doctor	32.1	28.0	32.7	28.4	29.3	32.0	30.7	30.1	28.9	29.4	33.1	31.4	27.6
Got telephone advice	21.5	9.9	12.8	17.9	17.5	11.2	10.2	15.7	19.5	16.8	11.3	13.8	20.0
Don't know	1.3	1.0	0.7	1.4	1.1	1.4	1.0	1.0	1.4	1.3	0.7	1.3	0.9
Other	6.8	3.2***	4.4	5.5***	5.2	4.3**	3.5	4.3	7.0***	5.3	4.2*	4.0	7.2***
No of respondents	1743	1646	1342	2047	2535	805	579	1614	1127	2466	601	2252	1137

*P<0.01; **P<0.001; ***P<0.0001.

theses): Medway Health Authority (2173; 69%), Canterbury and Thanet Health Authority (1781; 69%), and Cambridgeshire Family Health Services Authority (3635; 62%). The combined sample totalled 7589. When compared with the figures for England and Wales the sample had more women than men and slightly overrepresented older age groups. The three studies found remarkably similar results.

The table summarises results for three questions about out of hours consultations. The first—"Have you ever tried to contact the doctor out of hours?"—is a direct measure of demand. Just under half the sample had ever done so, and these tended to be younger, female, married, and home owners and to have two or more cars and to have left school later. In terms of what happened during such consultations, we asked both about the most recent occasion and generally. Asking about the most recent occasion prompted fewer "don't knows" and sharper divisions across all socio-demographic variables tested; respondents had had less success in seeing their own doctors and had received more advice over the phone.

With regard to satisfaction with out of hours consultations generally and on the most recent occasion, only age was significant as younger people tended to be less satisfied—a trend found for most dimensions of care. Of the whole sample, 79.6% were satisfied generally but only 67.3% were satisfied with the last out of hours consultation. Perhaps this indicates that the present changes affecting general practitioners' service outside normal hours have had adverse effects on patients' satisfaction.

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1 Hallam L. Primary medical care outside normal working hours: review of published work. *BMJ* 1994;308:249-53. (22 January.)

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3 Khayat K, Salter B. Patient satisfaction surveys as a market research tool for general practices. *Br J Gen Pract* (in press).

4 Le Touze S, Wall B. *Consumer satisfaction with primary care in Cambridgeshire*. Canterbury: Centre for Health Services Studies, University of Kent, 1993.

New start date for medical posts

Will cause confusion with registration

EDITOR,—T J S Chesser and F M E Wadsworth have drawn attention to senior house officers' lack

of awareness of the change in start dates for hospital medical and dental posts.¹ There seems to be an even more unpleasant surprise for junior doctors. Those with limited registration that expires with their current post on 31 July cannot have their registration automatically extended by the General Medical Council for a further two days. These doctors will need to reapply for an extension and will have to pay the normal fee. For example, German graduates in preregistration house officer posts who move on 3 August to a preregistration house officer post with a different employing authority will pay £70 to register for 1 and 2 August and a further £70 for the six months from 3 August.

The draft version of the executive letter announcing the changes was circulated to postgraduate deans with a tight deadline for comments.² Although two paragraphs addressed the financial consequences of the changes, the personal financial implications of extending the period of limited registration seem not to have been considered.

Major changes in medical education and staffing will take place as the recommendations of the Calnan report are enacted. It is to be hoped that the NHS Executive will allow more time for consultation and communication with those at the "sharp end" of the NHS.

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1 Chesser TJS, Wadsworth FME. SHO's unaware of new August start date. *BMJ* 1994;308:1043. (16 April.)

2 NHS Management Executive. *Introduction of compulsory induction courses and changing the starting day for hospital medical and dental staff*. Leeds: NHSME, 1994. (EL (94) 1.)

Directive should be withdrawn

EDITOR,—T J S Chesser and F M E Wadsworth¹ are right to point out some of the difficulties caused by the NHS Management Executive's ill considered directive introducing a compulsory change to starting dates for preregistration house officer posts.² The Junior Doctors Committee believes strongly that all house officer posts should start on a Monday; this would allow most house officers a free weekend to change jobs, which often entails moving considerable distances. Additionally, all house officers should receive an induction course, during which they should be paid, before starting clinical duties.

Worryingly, the directive has not adequately

permeated medical staffing departments; we face the prospect of some units having two sets of house officers and senior house officers while other units have none. The directive will have various other consequences, which were not thought through by the NHS Management Executive—for example, it will damage successful and carefully thought out local induction courses and specialist rotations.

The Junior Doctors Committee has therefore called for the directive to be withdrawn. Some of the directive's aims may be desirable, but the amount of thought, consultation, and publicity given to implementing these far reaching changes is woefully inadequate. The changes may serve only to make the lives of juniors still more difficult without improving patients' care.

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1 Chesser TJS, Wadsworth FME. SHO's unaware of new August start date. *BMJ* 1994;308:1043. (16 April.)

2 NHS Management Executive. *Introduction of compulsory induction courses and changing the starting day for hospital medical and dental staff*. Leeds: NHSME, 1994. (EL (94) 1.)

Car parking for doctors

EDITOR,—Recently I had to go for a test at the Royal Free Hospital. After driving through the early morning rush hour for nearly two hours I arrived to find chaos as half of the spaces in the patients' car park had been blocked off, for no apparent reason. I was later told that the spaces had been reserved for a meeting of general practitioners which was due to take place that lunchtime: "If we didn't block them off in the morning some of the doctors might find difficulty parking."

I am delighted that, at last, the NHS seems to be getting its priorities right.

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Correction

Tobacco policy

Two typesetting errors occurred in the letter by P D G von Eichstorff (7 May, p 1241). Computer records were audited over a three year period [not a three week period], and the practice cited for comparison had records on 24 of 271 children [not 24 271 children].