someone he or she has cared for for many years and may damage subsequent doctor-patient relationships with any member of the family or their close friends.

The second reason for general practitioners' reluctance to request necropsies is their wish to avoid the ever increasing threat of litigation and complaints. Should the patient be shown to have died of a condition that was not suspected before death the doctor is wide open to complaints and litigation by the relatives. The quoted figures that 15% of main diagnoses and 42% of causes of death were not confirmed at necropsy hardly make comforting reading when viewed in this context.² A doctor could find his or her career in ruins simply by requesting a necropsy that failed to confirm the antemortem diagnosis.

JOHN LEIGH
General practitioner

Washington,
Tyne and Wear NE38 9BT

- 1 Thomas KB, Weller RO. General practitioners and necropsies. *BMJ* 1994;308:1054. (23 April.)
- 2 Cameron HM, McGoogan E, Watson H. Necropsy: a yardstick for clinical diagnosis. *BMJ* 1980;281:985-8.

Transport costs unmet

EDITOR,—The editorial¹ and paper² on general practitioners and necropsies do not mention the main stumbling block to obtaining a necropsy on a patient who died in the community—namely, transport of the patient to the postmortem room. About three years ago I tried to obtain a necropsy on a patient with clinical sarcoid who died at home. There was no tissue diagnosis, and tuberculosis had not been wholly excluded. The pathology department (which was headed by the author of the report *Autopsy and Audit*³) was willing to perform the necropsy but insisted that the transport costs be paid either by me or by the patient's relatives. I am not in a fundholding practice and did not think that either source of funding for the transport was appropriate, so the necropsy was not done.

My second point relates to reports on coroner's necropsies. I have repeatedly requested written reports without success. In this area I am able to obtain only a verbal report, by telephoning the coroner's officer after the necropsy has been completed. Therefore I strongly support the proposal that necropsy reports should be sent to general practitioners routinely and preferably within a few weeks, before the patient's medical record is returned to the family health services authority.

PETER MCCARTNEY
General practitioner

St Peter's Street Medical Practice,
London N1 8JG

- 1 Thomas KB, Weller RO. General practitioners and necropsies. *BMJ* 1994;308:1054. (23 April.)
- 2 Berlin A, Wagstaff R, Bhopal R, Spencer J. Postmortem examinations: general practitioners' knowledge, behaviour, and attitudes. *BMJ* 1994;308:1080-1. (23 April.)
- 3 Slavin G. *The autopsy and audit. Report of the joint working party of the Royal Colleges of Pathologists, Physicians (London) and Surgeons (England)*. London: Royal College of Pathologists, 1991.

Service may not be available

EDITOR,—I agree that general practitioners should receive copies of coroners' necropsy reports and that more non-coroners' necropsies are necessary for medical audit and education,^{1,2} but these may be difficult to implement in practice. With the advent of purchaser-provider contracts it is wrong to assume that a service for non-coroners' necropsies is automatically available. Personal conversation with colleagues indicates that the provision of non-coroners' necropsies has largely been omitted from contracts with district health authorities with reference to non-fundholding and fundholding general practitioners. Indeed, its inclusion in such

contracts in future seems unlikely in view of increasing workloads in histology and minimal expansion of the number of pathologists. In addition, the cost of transporting a body from the place of death to the mortuary must not be overlooked; in some areas this cost has been borne by relatives.

Currently, copies of coroners' necropsy reports can be released only with expressed permission. This practice varies widely throughout Britain and warrants central legislation to allow the release of reports to general practitioners. In some areas the non-availability of coroners' necropsy reports is to a degree circumvented by the coroners' rules, which require coroners to notify the dead person's regular medical attendant of the date, time, and place of necropsy.³ Implicit in this is the desirability for general practitioners to attend the necropsy and personally observe the findings, although this is often not feasible. In my experience, however, the prime requirement of many general practitioners is rapid notification of the cause of death, so that relatives can be counselled appropriately.

As practised locally, after the necropsy has been undertaken general practitioners should be encouraged to telephone the pathologist and discuss the necropsy findings. Such communication invariably proves invaluable for both the general practitioner and the pathologist,

DAVID SLATER
Consultant histopathologist

Rotherham Hospitals NHS Trust,
Rotherham S60 2UD

- 1 Thomas KB, Weller RO. General practitioners and necropsies. *BMJ* 1994;308:1054. (23 April.)
- 2 Berlin A, Wagstaff R, Bhopal R, Spencer J. Postmortem examinations: general practitioners' knowledge, behaviour, and attitudes. *BMJ* 1994;308:1080-1. (23 April.)
- 3 Burton JDK, Chambers DR, Gill PS. *Coroners' inquiries: a guide to law and practice*. Middlesex: Kluwer Law, 1985:34.

More sophisticated studies needed

EDITOR,—Anita Berlin and colleagues' questionnaire survey of general practitioners' knowledge of and behaviour and attitudes towards necropsies addresses some of the straightforward issues but few of the difficult ones.¹ Our experience supports their observation that many general practitioners know that they can request clinical (non-coroner's) necropsies, but few do so in practice. The authors' only explanation for this relates to the complexities of arranging such an unusual procedure, yet the authors claim to have assessed the attitudes of general practitioners towards necropsies. Opposition from relatives, confidence in clinical diagnoses, and the level of general interest in necropsies among doctors, including pathologists, are the most influential factors in any decision to request a necropsy,² and these were not discussed in the study.

The paradoxical finding that many general practitioners believe that more necropsies should be requested to improve medical audit but that rates of request remain low is similar to the situation that exists in some hospitals and requires further attention. Studies would be enhanced by collaboration with pathologists (none of the authors of the paper seem to be pathologists) and psychologists. Input from these informed sources would enable a more detailed analysis of behaviour, intentions, and attitudes with regard to necropsy.^{3,4} More necropsies will be requested only as a result of the requesting clinicians' belief in the practical utility of information obtained and the re-education of doctors from all disciplines.

Access to necropsy reports should be encouraged, but it is naive to suggest that this would have an appreciable influence on behaviour with regard to requests for necropsies. Hospital doctors have had constant access to necropsy reports, and rates of clinical necropsy continue to decline.⁵ The problem is far more complex than the authors

suggest and requires more sophisticated investigation.

ROGER D START
Lecturer
DENNIS W K COTTON
Reader

Department of Pathology,
University of Sheffield Medical School,
PO Box 596,
Sheffield S10 2UL

- 1 Berlin A, Wagstaff R, Bhopal R, Spencer J. Postmortem examinations: general practitioners' knowledge, behaviour and attitudes. *BMJ* 1994;308:1080-1. (23 April.)
- 2 Start RD, Hector-Taylor MJ, Cotton DWK, Startup M, Parsons MA, Kennedy A. Factors which influence necropsy requests: a psychological approach. *J Clin Pathol* 1992;45:254-7.
- 3 Birdi KS, Start RD, Cotton DWK, Bunce D. A psychological evaluation of factors influential in clinician necropsy requests. *J Pathol* 1993;170S:374A.
- 4 Sherwood SJ, Start RD, Birdi KS, Cotton DWK, Bunce D. Why do patients' relatives refuse permission for autopsies? *J Pathol* 1994;172S:149A.
- 5 Start RD, McCulloch TA, Benbow EW, Lauder I, Underwood JCE. Clinical necropsy rates during the 1980s: the continued decline. *J Pathol* 1993;173:63-6.

Women consultants and merit awards

EDITOR,—Women consultants are poorly represented among holders of merit awards (20% hold awards, compared with 37% of men). Two possible partial explanations have recently been suggested.¹ Firstly, the age distribution of women consultants, which is skewed towards younger age, means that they are less likely to have awards than their older male counterparts because the chances of having an award increase with age. Secondly, the specialities that women choose to go into particularly radiology, anaesthetics, paediatrics, public health, and psychiatry—are relatively poorly represented with regard to awards.

Age could be taken account of if the available data on the proportion of consultants with merit awards were presented by age and by sex to determine the extent to which this suggestion applies. The association of women with specialities poorly represented among merit award holders means that this is the cause of the difference between the sexes. Possibly these specialities are less well rewarded because many of the specialists in them are women, who as a group are less likely to be put forward for an award. In addition, the specialities listed are not as poorly underrepresented as might have been expected from the comment (all specialities 34.4%, paediatrics 35.4%, anaesthetics 28.7%, public health 28.5%, mental illness 27.8%, radiology 25.7%).² Probably, however, within each of these specialities a lower proportion of women than men hold awards.

Publication of more disaggregated information on holders of merit awards would help to clarify the situation and ensure that the discussion was based whenever possible on fact rather than opinion.

ALLISON STREETLY
Locum consultant in public health medicine

South East London Health Authority,
London SE1 7RJ

- 1 Beecham L. Women consultants lag behind in merit awards. *BMJ* 1994;308:1106. (23 April.)
- 2 Secretariat of Advisory Committee on Distinction Awards. Distinction awards: analysis by type of ward, specialty and percentage distribution at 31 December 1992—England and Wales. *Health Trends* 1994;20:152.

Merit awards

EDITOR,—I am a member of a regional higher awards committee. Though I approve of the merit awards system, I have several reservations. I agree with Jeffrey Tobias that all consultants are not equal and that some system is required to acknow-

ledge this.¹ I too reject the notion of seniority payments and believe that the system is, in its way, performance related.

My concern is with the selection of people for awards. It has not seemed sinister, oversecretive, very unfair, or slapdash. Both locally and regionally a great deal of honest effort has gone into the process, and the outcome has not seemed too wide of the mark. But the application of the stated criteria has been inconsistent, and opinions have been sought from too narrow a range of people. Examples are an overemphasis on academic achievement by people holding academic posts; a tendency to ignore the circumstances under which regional consultants work; a preoccupation with potential rather than actual achievement; and an underemphasis of the importance of the person's contribution to the NHS.

I suspect that the people who know most about the overall quality of a consultant's performance are nurses, junior doctors, general practitioners, patients, and managers. I see no reason why a discreet method of consultation with these people could not be devised. Conversely, great care needs to be taken when consulting a senior member of a specialty, who may turn out to be influencing opinions that seem to be coming from several different sources. Some people's prospects may have been blighted in this way and others' unjustifiably enhanced.

To me, the secrecy and inconsistencies occurred at the national rather than regional and local levels. I was often frustrated at meetings with the national chairman, and I have not been alone. Strong cases have been dismissed and weak ones accepted. The chairman may know things that I don't, but it would engender much more confidence in the local and regional representatives if explanations were offered for decisions taken. Fair play needs to be seen to be done.

The unequal distribution of awards among specialties continues. So does the inequitable number of awards to women, about which I was not reassured by the chairman. One improvement would be to increase the number of C awards and reduce the number of higher awards. Too many people who deserve C awards don't get them. Discrimination after this becomes easier.

A great deal of money is disbursed through this system. A C award, for example, is more than my secretary earns in a year. It behoves us all to treat this process seriously, with wider consultation and greater equity and openness at all levels.

G D P WALLEN
Consultant psychiatrist

Wonford House Hospital,
Exeter EX2 5AF

¹ Tobias J. In defence of merit awards. *BMJ* 1994;308:974-5. (9 April.)

Performance related pay

Management could limit amount of work done

EDITOR,—I read that Mrs Bottomley has communicated with the BMA concerning performance related pay.¹ As a surgeon, I wish to express my disapproval. At present doctors are paid a salary that bears no relation to the amount of work performed. Furthermore, compared with the salaries of other professions of equal standing and responsibility this is a meagre amount, compensated only by volunteer private practice. I do not wish to divide the profession but should be interested to compare NHS surgical and medical workloads, which are rewarded by equal NHS salaries.

One argument states that you should be paid only for work that you do: this is one of the principles of private practice. In the NHS as it is

now run, however, a different principle applies—that is, you will be paid for work that you are allowed to do. The management—under the financial control of commissioners (forget fundholders for a moment)—can limit the amount of work a surgeon does by closing a theatre, failing to secure the employment of a locum anaesthetist or junior surgeon, or simply reducing the number of beds. This is currently because of underpurchasing by the commissioners but could be used as a means of limiting salaries. The lack of funds closes so many facilities that fundholders are unable to get their patients admitted. Surgeons cannot then earn money from that source even if it was ethically desirable.

The government of Canada reduces doctors' pay by paying doctors for work done and then making sure that there are ceilings to the work done.

If the BMA caves in on this issue, as it seems to have caved in on so many issues in the market economy, I will resign, and I hope that all doctors both young and old would see their impecunious futures and resign too. Performance related pay may also include merit awards, but we have no idea how merit would be defined under such conditions as apply to the market economy.

Surgeons know what they can do if they are allowed to get on with the job. Unfortunately, they are easy targets when limitations are placed on the freedom to achieve.

ELLIS FIELD
Consultant surgeon

Brook General Hospital,
London SE18 4LW

¹ Beecham L. BMA protests about performance related pay in the NHS. *BMJ* 1994;308:1443. (28 May.)

Is a trick to contain salaries

EDITOR,—I have received performance related pay¹ since retiring from the Royal Army Medical Corps in 1985. The American industrial model of performance related pay, unlike the structured salary scales of the army and the NHS, is intended to promote productivity, which a non-medically trained management simplistically translates into throughput of patients—that is, 20 tonsillectomies a week indicates higher productivity than three hysterectomies. I have never considered medicine to be comparable to a production line, yet if performance related pay is implemented in the NHS medical staff will be compelled to abandon the attitudes and work ethics of generations and to assume those of hourly paid car workers. Patients with complicated problems are shuffled from one department to the next lest they create a blip in the statistics. Better to exclude them from care—a variant of two tier general practice perhaps—or, best, refer them to a megacentre, which has a more flexible budget.

In a system based on performance related pay someone has to decide on each doctor's "annual performance evaluation." In this tertiary referral centre a category 1 rating permits a "merit award" (pay rise) of 7.5-10%. A category 5 rating results in summary dismissal. Most members of the medical staff are awarded a category 2.5 (a pay rise of 5.7-7.5%) as this numerical value is the mean, mode, and median of the gaussian normal distribution curve and is where most staff "fit the curve." Only x staff can be rated category 1 and y rated category 5; no matter how well a person may perform—unless he or she is outstanding or appalling—a performance category to fit the curve will be allocated. Thus performance related pay may be considered to be a straightforward and effective management tool to contain and drive down salary costs—in short, either a mathematical sham or a confidence trick.

The imposition of performance related pay amid secrecy and deception generates an intensely negative effect on performance; this added to the diktats of quality assurance and continuous quality

improvement and the dark threat of continuous medical education causes anger, frustration, and occasionally despair and results in diminished clinical effectiveness. These transatlantic imports may all be seen as being based on the assumption that medical staff are either lazy or incompetent, or both. What does that imply about our peers whose lifetime's achievements have not been guided by such august management tools?

The present structured salary scale merit awards may not be perfect. But mix in the incentive of private practice and you have a doctor who is infinitely more productive than one whose performance is rated as being in category 4 by a junior pay clerk who has to join up the dots on the distribution curve flashing on the computer screen.

RICHARD KNIGHT
Consultant anaesthetist

Box 9134,
Aramco,
Dhahran 31311,
Saudi Arabia

¹ Beecham L. BMA protests about performance related pay in the NHS. *BMJ* 1994;308:1443. (28 May.)

Aspirin and suspected myocardial infarction

EDITOR,—Michael Moher and Neil Johnson, and also Hazel R Wyllie and Francis G Dunn, cite the second international study of infarct survival (ISIS-2) to recommend that general practitioners should carry aspirin and give aspirin to patients with suspected acute myocardial infarction before transfer to hospital.^{1,2} They imply that giving aspirin three or four hours before the patient receives thrombolysis, rather than giving aspirin with thrombolysis, would save more lives. And the editorial accompanying the articles berates general practitioners for not heeding evidence.³

In ISIS-2, patients were given 160 mg aspirin or placebo tablets to chew along with intravenous streptokinase, or a placebo infusion followed by oral aspirin or placebo tablets.⁴ One component of the study was whether aspirin with or without thrombolytic agents in acute myocardial infarction (not whether aspirin given before or with thrombolysis) has a role in acute myocardial infarction. Quoting the benefit of aspirin with thrombolytics in ISIS-2 is out of context with what the authors of the two articles are suggesting, that aspirin given before thrombolysis saves more lives than does aspirin with thrombolysis.

The benefit of intravenous thrombolysis is time dependent. Early use saves more lives. Used within four hours of onset of chest pain, thrombolysis saves more lives than it does used five to 12 hours after the onset of chest pain.⁴ No such dependence was seen with aspirin use in ISIS-2 (table): giving aspirin within four hours of onset of chest pain does not save more lives than giving aspirin five to 12 hours afterwards. Thus the evidence from ISIS-2 is contrary to what the authors are suggesting, and no study has been done to see whether aspirin given before thrombolysis has any benefit over aspirin given with thrombolytic agents.

Aspirin is no substitute for early thrombolysis in the management of acute myocardial infarction.

Effect of aspirin given in suspected myocardial infarction

Hours onset of chest pain	No of patients	No (%) of deaths from myocardial infarction
0-4	3733	332 (8.9)
0-1	356	34 (9.5)
2	953	80 (8.4)
3	1243	109 (8.7)
4	1181	109 (9.2)
5-12	3633	366 (10.0)
12-24	1221	106 (8.7)