a high proportion of aggrieved patients, but it is more relevant that no patient was thought to have left the practice because of the change despite the communication strategy having been hastily constructed and having reached only 73% of the respondents. We suggested not that patients will welcome such changes but that they will accept them.

We believe that David J Torgerson and Alan Maynard's first assertion, that inefficient prescribing of any type deprives other patients of health care resources, is correct. As Birchall and colleagues imply, the Downfield surgery's prescribing practices only moved towards the national norm and do not reflect use of inferior products or exceed recommended practice. There remains a need for "good" prescribing in primary care to be defined, although morbidity data are so crude that they could not be applied at practice level in the foreseeable future.

We contend that all practitioners should aim to prescribe in line with the accepted best practices, which includes using the most economical preparation suitable. We have shown that this can be achieved rapidly without an unacceptable backlash from patients. We believe, therefore, that practitioners should not be deterred from initiating changes in prescribing for fear of patients' response, provided care is taken to inform patients.

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Continuing medical education does not guarantee standards

EDITOR,—In her editorial on recertification of general practitioners Tessa Richards correctly identifies the weakness of the General Medical Services Committee's proposal when she says that "little evidence exists that accumulating continuing medical education 'credits' improves performance or affects outcomes."¹ Sadly, the profession cannot claim that participation in continuing medical education provides any guarantee of the standards of practice of a general practitioner. If recertification is to provide quality assurance for the public and health authorities it must also address the maintenance of competence and performance of doctors.

The public might reasonably expect that a doctor who has been recertified has assessed his or her educational needs, has undertaken appropriate continuing education, has shown that his or her clinical knowledge is up to date, can recognise emergencies and serious conditions and deal with them safely, can manage common conditions optimally, can perform necessary procedures competently, makes himself or herself available and accessible to patients, consults in an effective and patient centred manner, and adheres to ethical standards of professional behaviour. These expectations are deliberately arranged in a hierarchy of education, competence, and performance. Only the first two are addressed by the proposal of the General Medical Services Committee. To certify a doctor's standards in the others will inevitably require some form of testing and observation of practice. The methodology and logistics may be difficult, but if we are not prepared to grasp this nettle then recertification will amount to no more than "son of postgraduate education allowance."

A second problem with the proposals is that they replace a financial incentive to continuing education with a disciplinary one. Whereas practitioners could choose not to qualify for postgraduate education allowance, non-compliance with the proposed mentoring scheme would result in a visit from the regional advisory reaccreditation team and the ultimate threat of suspension. This

amounts to the compulsory imposition of an untested system and would undoubtedly be viewed by the recipients in the same light as they viewed the 1990 contract. Personal learning contracts with mentoring is a promising new technique with the potential for general practitioners to recapture personal control over and responsibility for their continuing education. The mentoring relationship depends, however, on mutual trust, and the value of a personal learning contract depends on individual motivation; it cannot be inferred that the same value will be obtained when the process is not entered into voluntarily.

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Use of albumin

EDITOR,—Neil Soni concludes that the theoretical advantages of albumin as a colloid replacement fluid are not translated into overt clinical benefits. Quite apart from this, albumin is extremely expensive: in our hospital 100 ml of 20% solution and 500 ml of 5% solution each cost £30.

With the imminent introduction of invoicing of individual clinical departments for blood products used, we audited the use of albumin, among other products, over 12 months. The four main users were gastroenterology (22.5 litres), general medicine (29 litres), paediatrics (109 litres), and general surgery (287 litres). In general surgery all the albumin was used for patients in the intensive care unit, which now holds a separate budget from that of the department of surgery. The indications for using human albumin solution, at a total cost during the year of £31 680, were rarely based on published guidelines such as those in *ABC of Transfusion*.²

We believe that the only indications for using albumin in our hospital are the resuscitation of neonates and the treatment of oedema resistant to diuretics. By introducing a system whereby albumin solutions will be released only after the completion of a form listing the indications for their use, we hope to cut the amount of albumin used by at least half; this would translate into a minimum saving of £15 840.

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Roger's ants: a new pest in hospitals

EDITOR,—We wish to report what we believe to be the first infestation of a hospital by Roger's ants (*Hypoponera punctatissima*). Winged ants were first sighted around the nurses' station in the cardiac intensive care unit in October 1994, and several members of staff reported multiple stings from the ants. The likely source of the infestation was found to be a wall cavity behind a wash hand sink. A persistently leaking waste pipe had damaged plaster boards and cavity timbers and had soaked the concrete floor. The area was heavily populated with sewage flies (*Psychoda alternata*), and many live winged female Roger's ants were crawling in the wall cavity and feeding on the larvae of the flies. The ward was closed, the pipe repaired, and all excess water cleared away to allow the pest

control officer to treat the area with insecticide. The ants were thought to have gained access to the cavity through an expansion joint in the concrete floor. Microbiological examination of the ants showed them to be colonised primarily with *Streptococcus lactis* and the mould *Cunninghamella elegans*.

As far as we are aware, this is the first description of a hospital infestation with Roger's ants. Infestations with Pharaoh's ants (*Monomorium pharaonis*) have, however, been recognised to be a problem in hospitals for many years.¹

Both Roger's and Pharaoh's ants are largely tropical in origin and associated with humans in Britain, normally found infesting permanently heated premises. Roger's ants have been found in conservatories, bakeries, and hotels. Both species have a high requirement for moisture, being attracted to drains, toilets, and other wet areas. Pharaoh's ants nest in large colonies, follow pheromone recruitment trails to food sources, and are omnivorous. Roger's ants nest in small colonies in damp soil residue, do not follow trails, and are carnivorous, foraging for live prey and killing larvae and pupae of small insects by injecting a powerful venom through their well developed sting. Roger's ants can also sting humans. In most people a sting results in a dermal weal and flare reaction followed by the development of a 1 cm erythematous, pruritic papule that lasts several days. It is possible that, like other members of the Hymenoptera, they may rarely induce a systemic allergic reaction. Pharaoh's ants represent an infection hazard in hospitals. They have been found in sterile supplies² and in sets for giving intravenous fluids.³ A range of pathogenic bacteria, including *Salmonella* spp, *Pseudomonas aeruginosa*, and *Staphylococcus aureus*, has been isolated from them.⁴ Roger's ants probably also represent a potential risk of cross infection as well as having an unpleasant sting.

It is important to recognise Roger's ants so that effective pest control measures can be carried out: because they feed exclusively on live prey they are not attracted to poisoned bait like Pharaoh's ants are.

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Correction

Drug treatment of Parkinson's disease

An author's error occurred in the letter in this cluster by Niall Quinn (24 June, p 1668). The penultimate sentence of the first paragraph should have read: "Scores below the lower limit of the 95% confidence interval for controls were found in 75% [not 51%] of patients with idiopathic Parkinson's disease, 31% of those with multiple system atrophy, 20% of those with progressive supranuclear palsy, and none of the seven with corticobasal degeneration who were tested."