while always maintaining highest medical standards. How best to achieve this will vary depending on local needs, interests, skills, and geography, and the only way forward is by dialogue, collaboration, and cooperation. Departments that remain blinkered and defensive will not serve the community and are more likely to wither while their populations continue to be at risk.

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Calculating drug doses

Mass concentration can't be used universally

EDITOR,—S Rolfe and N J N Harper draw attention to the NHS specification for ampoule labels and suggest that all drugs should be measured as mass concentration.¹ The original work that was undertaken on ampoule labelling arrived at the same conclusion.² Wider discussions with practitioners when the NHS specification was being prepared highlighted potential dangers of making the changes that Rolfe and Harper now request. The NHS specification also recognises that many biological products—for example, vaccines—cannot be defined in terms of mass concentration.

Lee Baldwin suggests that adopting a standard for type size might enable more information to be placed on ampoule labels.³ The particular problem with ampoule labels is their small size. The information on the labels needs to be kept to a minimum so that essential information, defined in the NHS specification as volume, generic name, amount, route(s) of injection, and expiry date, are clearly legible.

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Teaching of undergraduates must be improved

EDITOR,—I have always found it curious that the drugs whose concentrations are most likely to be expressed as per cent or as 1 in x thousand are also the most important drugs used in resuscitation. One can speculate on the reluctance of the appropriate authorities to tamper with the presentation of such important drugs, yet it comes as no surprise to find that most doctors are unable to deal with these expressions of concentration effectively.¹ Although anaesthetists scored highly in the survey of S Rolfe and N J N Harper,² I believe that the results of the survey reflect poorly on our specialty.

The performance of anaesthetists in the survey merely illustrates the importance of familiarity in being able to make these simple calculations reliably. Most of the staff called on to use these drugs in the emergency setting, however, do not have this same benefit of familiarity. Until we

express all concentrations as mass per unit volume, as Lee Baldwin suggests,² we should ensure that all medical staff, and in particular junior doctors involved in resuscitation, are able to use the current units of concentration correctly. This responsibility must fall to anaesthetists since medical students receive most exposure to drugs whose concentrations are expressed in this way when they are being taught anaesthetics. Unfortunately, in my personal experience, from several different regions, this does not happen at present. Whereas most medical students reaching the end of their anaesthetic module will, for example, be able to describe the differences between various neuromuscular blocking agents, they cannot even begin to explain what is meant by a 2% concentration of a drug. More seriously, nobody has ever explained the expression to them, let alone emphasised it.

My impressions are borne out by the current survey, which suggests that, in addition to improving the expression of drug concentrations, we might also ensure that current teaching of undergraduates provides the best preparation for routine clinical practice.

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Provision of screening for Down's syndrome

EDITOR,—There are no official statistics on the extent or type of maternal serum screening for Down's syndrome. An ad hoc survey found that in 1991 one third of pregnancies in Britain were screened, less than half for multiple markers.¹ We have obtained more recent data from the United Kingdom national external quality assessment scheme for screening for Down's syndrome.

The primary purpose of the scheme is to monitor analytical and interpretive quality, and currently 78 laboratories participate. Although there is no legal requirement to join the scheme, participation is a condition for accreditation of the laboratory. Each month samples are distributed for assay of concentrations of α fetoprotein, unconjugated oestriol, intact human chorionic gonadotrophin, and free β human chorionic gonadotrophin as appropriate.²

A questionnaire was included with the samples distributed in November 1994, requesting the annual number of pregnancies in the geographical area served, the number of women screened annually, and the current weekly number and size of analytical batches tested. The product of the batch number and size multiplied by 52 is an indirect estimate of the laboratory's annual throughput of specimens. All but 10 questionnaires were returned.

The number reported as being screened annually was 354 549, or 44% of the estimated 802 230 pregnancies (from projections of births in the United Kingdom,³ increased by 2% to allow for late miscarriages). If it is assumed that the laboratories that did not respond to the questionnaire had similar screening activity to those that did respond, 51% of pregnancies will have been screened.

The total reported laboratory throughput was 423 072 specimens (table), nearly all of which were tested for multiple markers; this figure is one fifth greater than the number of pregnancies reported as screened. While part of the excess is accounted for by repeat testing, most will be due to throughput

Laboratories' annual throughput of specimens according to combination of markers used

Combination of markers	No of laboratories	Annual throughput
AFP alone	1	4 316
AFP and intact hCG	35	208 728
AFP and free β hCG	22	121 160
AFP, unconjugated oestriol, and intact hCG	6	54 184
AFP, unconjugated oestriol, and free β hCG	4	34 684
All	68	423 072

AFP = α fetoprotein; hCG = human chorionic gonadotrophin.

being a better reflection of recent increases in screening activity. On this basis the proportion of pregnancies screened may have increased to almost 60%.

Not all laboratories were able to give the number of pregnancies in their geographical area, but those that could reported a total of 485 022, with 321 069 (66%) being screened. This proportion is an estimate of the rate of uptake in areas where screening is offered, but it is a minimal estimate since the offer may be restricted, for example, to older women.

Provision of maternal serum screening for Down's syndrome has changed considerably in recent years: it has become extensive, and more markers are being used. Our survey shows that the information needed to assess current practice can be readily obtained from the United Kingdom national external quality assessment scheme. We suggest that this source be used to monitor any future changes.

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Ongoing electronic conference is available for general practitioners

EDITOR,—The importance of the Internet has already been recognised in public health,¹ and Coiera points to the potential of the Internet as an enormous information resource, to which the *BMJ* now contributes.² Tony Delamothe suggests that the *BMJ*'s presence on the Internet may also change the one to many relationship that the journal has with its readers.³ As well as reading web pages, "net surfers" with shared interests can correspond by joining a listserver, which is an ongoing electronic conference.

Mailbase is the main electronic mailing list service in the United Kingdom, and it enables groups to manage their own discussion topics (Mailbase lists) and associated files. The service is run by a dedicated team based at Newcastle University and is funded by the Joint Information Systems Committee of the Higher Education Funding Councils for England, Scotland, and Wales. A Mailbase list specifically discusses