that performance indicators as introduced by family health services authorities will be used punitively to identify deficiencies and exert control. Continuous quality improvement aims not to blame but, instead, to seek the root causes of a failure in process that can be improved.³ Important tenets of continuous quality improvement are that efforts for improvement are internally driven, not an external mandate; that it focuses on systems first and individuals second; that it recognises that error free care cannot be guaranteed but instead emphasises that the quality of care can always be continuously improved; and that the commitment of leaders is necessary.²

Quality of care should be assessed and monitored and efforts made to improve standards. Nevertheless, the imposition of performance indicators by family health services authorities without consultation and negotiation is unlikely to be as beneficial as a well planned quality improvement programme that aims to get each primary health care team continually to improve the quality of care provided. As with many things that are imposed, people will try to find ways of cheating the system and of going through the motions of monitoring and evaluation while not really believing in them.

Performance indicators can certainly be useful, but they should be only one of many tools used in a much wider programme that seeks to improve quality of care. It is also vital that any such project be proactive and a collaborative effort between management and all those in the front line of the provision of health care.

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Inadequate smears are not always due to poor technique

EDITOR,—F Azeem Majeed and Simon Voss suggest that the creation of certain performance indicators by family health services authorities may benefit general practitioners by exposing areas in which their practice deviates from the norm and in which further investigation or audit may therefore be appropriate.¹ They give as an example the proportion of cervical smears that are technically unsuitable for examination.

Just such an audit by Sefton Medical Audit Advisory Group has highlighted a problem with the single code provided for such smears by the cervical cytology form HMR101/5/C and the effect that this may have on general practitioners' ability to attain cytology targets. Mandatory use of the form limits laboratories to using code 1 ("inadequate specimen") in box 22 ("cytological pattern") to report all smears that, for whatever reason, are unsuitable for screening. Under this system, smears that are truly inadequate (because they are scanty, air dried, or from the wrong part of the cervix) and that may therefore indicate a deficient technique for taking smears are lumped together with smears that may be unsuitable for other reasons (because they are bloodstained or obscured by polymorphs).

Whether or not one agrees with the principle that poorly taken smears should not count towards cytology targets, it is patently unfair that general practitioners should be penalised for taking smears that, for reasons outside their control, are unsuitable for screening. In North Sefton this problem has been exacerbated by the changes adopted

by the laboratory to bring its reporting system in line with national guidelines (by abandoning its category of "negative repeats" for smears obscured by polymorphs). This limited coding also makes the data produced by the family health services authority's computer useless for any meaningful audit of unsuitable smears. Sefton Medical Audit Advisory Group and the Sefton Cytology Core Group have written to the Department of Health on this subject, strongly suggesting that the forthcoming changes to form HMR101/5/C address this problem, which must be relevant to every practice in Britain.

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Factors influencing participation in audit

EDITOR,—Richard Baker and colleagues propose that advisory groups will need to devise strategies to encourage higher levels of participation in audit.¹ They also suggest that the most important factors influencing participation are attitudes towards audit and the audit group, and discussion in the practice about participation.

Audit is a minimum criterion required by the Joint Committee for Postgraduate Training for General Practice for all training practices. Summative assessment will affect all trainees who complete their training after 1 September next year and will include a submission of practical work. The current recommendation that, for the first few years, this should be audit is likely to have a considerable impact on the factors mentioned by Robin C Fraser and Baker and colleagues.²

Summative assessment for vocational trainees has been developed in the west of Scotland, and for the past three years every trainee has carried out an audit. Two years after audit was introduced its impact was assessed on 117 trainees in May 1994; 104 (89%) responded.³ As a result of their experience 99 of the trainees felt more confident about introducing change in their next practice and for 82 trainees this was their first practical experience of audit.

Time is always mentioned as a barrier, but our study showed that most trainees spend little more than a working week on an audit project and that this time could be reduced if more of the practice team participated in the audit.⁴ The study also showed that trainees who chose their own project were more likely than those who did not to collect two sets of data and therefore were more likely to have had the chance to experience change in the delivery of care. This work has also allowed the development of a marking system based on defined criteria,⁵ and this is available throughout the region and alerts trainers to the necessary components of audit.

The work described will go a long way to changing attitudes and to meeting many of the difficulties experienced by Baker and colleagues and Fraser and colleagues.

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Authors' reply

EDITOR,—J R M Lough and colleagues suggest that audit undertaken by trainees or registrars in general practice and forming the practical work to be submitted as part of summative assessment will change the attitudes of future general practitioners towards clinical audit. We agree that this is desirable and that the scheme reported by McKay *et al* shows how good organisation and the whole-hearted commitment of trainers and advisers can have a major impact.¹ Nevertheless, when adopted in other parts of the country, this approach might not be as successful as it has been in the west of Scotland.

If some trainers are themselves unsure about the value of audit they may fail to promote interest or positive attitudes among their registrars. In these circumstances, when compulsion is introduced, resistance or antagonism may increase further and registrars may conclude that audit is a tiresome chore best completed with the minimum of active participation. As a result they would be unlikely to learn that audit is a worthwhile method of improving the quality of their work. As principals they would then avoid audit if possible.

It is therefore essential that all trainers and advisers learn the lessons of the experience in the west of Scotland and consider their views about audit. If they learn how audit can be practical and effective they will then be able to show by personal example that it is an important method of improving quality and should be a routine part of every general practitioner's professional life. Otherwise, suspicions held by the present generation of general practitioners about the desirability of examining the quality of their work and trying to improve it if necessary will be passed on to their successors.

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Health authorities use panels to gather public opinion

EDITOR,—Whether the public should be explicitly involved in decisions about health care is the subject of debate. Some researchers have found that members of the public are reluctant to state a view¹ or prefer decisions about the allocation of health resources to be made by doctors.² The debates that have begun to take place over the rationing of health care³ have, however, made the issue more open, and many people believe that the public can no longer be allowed to remain ignorant of decisions that concern them.

One of the ways in which health authorities might find out public opinion about priorities for, and views about, health services is by periodically consulting a standing panel that is more or less representative of the local public. Last March we carried out a survey of all directors of public health in Britain to ascertain how many health panels existed and the number of authorities in which the idea of forming a health panel was being considered. Altogether 136 directors of public health were sent a short questionnaire; 101 questionnaires were fully completed (response rate 74%). Twenty five respondents indicated that a health panel had been established in their authority, and a further 25 indicated that plans existed to create new health panels (in seven authorities these plans had reached an advanced stage).

Our sample may have been biased, but even if all the non-respondents worked in health authorities that did not use panels our results would still indicate that panels are now a widely accepted means of gathering public views about health care. Nevertheless, it is debatable whether the spread of such panels is desirable. No matter how carefully populations are sampled, selective participation may make responses less representative. Arguably, however, the responses would be less selective than responses from groups of patients' or appointed bodies such as community health councils. Attrition of members of the panel may not, however, be random, with the result that a sample will become progressively less representative. Thus panels may not only be more expensive than one off surveys or other means of eliciting public opinion but they may provide less valid answers. Possibly, too, the fact that someone is a member of a health panel may result in his or her views changing: as members become more informed they may become more like professionals in the way that they make decisions. This may be good or bad, depending on whether it results from a true understanding of a problem or from indoctrination into the current way of clinical thinking.

Many of the issues affecting panels—for example, possible systematic changes in expressed opinions with attrition of the members—can be studied through empirical research. As more panels come into existence a study of their characteristics and behaviour becomes more urgent.

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Analgesic effects of sucrose were known to the prophet

EDITOR,—Muslim doctors in Britain will have been interested to read Nora Haouari and colleagues' paper showing the analgesic effects of sucrose.¹ Practising Muslims all over the world rub pieces of chewed dates inside the mouth of newborn babies before circumcision on the grounds that the last Prophet Muhammad did this many times to newborn children.

Copying the prophet in all his actions (Sunnah) and obeying all his sayings (Ahadith) are basic to our belief, and the medical wisdom of giving dates (which are 70-80% sugar in the form of glucose and fructose) before circumcision is clear. I recom-

mend that the authors should investigate the use of sugar from dates in their trials of sugary substances as analgesia.

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BMJ should review its policy on reprints

EDITOR,—Richard Smith and Tony Delamothe wish to further the dream of their distant predecessors who wrote: "Those whom seas sever and distances divide the *BMJ* now joins in close communion and frequent converse on common... scientific interests."¹ We wonder how they reconcile these sentiments with the BMJ Publishing Group's policy of charging authors for reprints of published articles.

Reprints are vital in parts of the world without photocopiers and in some areas are the only source of scientific information.² The circulation of reprints fosters a spirit of solidarity among scientists² and is an efficient way of obtaining copies of a large number of articles.³ Sadly, European reprints are in terminal decline, and the BMJ Publishing Group seems indifferent to their demise.

Many medical journals, including the *Lancet*, provide authors with up to 100 reprints free of charge, but this is not the case with journals published by the BMJ Publishing Group. Authors are unwilling to fund the cost of reprints and for their own record will often settle for a photocopy. They cannot, however, provide photocopies in lieu of reprints to other people without breaching copyright.⁴ Consequently, those working in less privileged countries are seriously disadvantaged. The BMJ Publishing Group's policy causes greatest hardship to those in greatest need.

Last year, Kale reported on a conference held at BMA House, entitled "Getting information from the developed to the developing world." He highlighted the paucity of relevant health information in developing countries and in eastern Europe, discussed the inefficiency of various methods of distribution, and included a plea that systems for transferring information that "allow people [in such areas] to select the material themselves." Reprints were not mentioned.

It is to be hoped that global development of electronic means of publishing and distribution will reduce inequalities in access to medical and scientific information. In the meantime, the BMJ Publishing Group could show that it recognises the importance of reprints by reviewing its policy of charging for them.

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*The BMJ Publishing Group does not provide free reprints to its authors because printing reprints is expensive, and we think that the costs outweigh the benefits. We would rather spend the money on providing free subscriptions to some centres in the developing world. As copyright

holders we have no objection to authors sending photocopies of their articles to individuals in the developing world who could not otherwise easily obtain them.—EDITOR

Concern about "lookback" exercise for hepatitis C

EDITOR,—Nigel Higson expresses concern about the national "lookback" exercise being undertaken to detect recipients of blood donations originating from donors subsequently found to be positive for hepatitis C virus. Those of us in the transfusion service who are supervising the lookback exercise share several of Higson's concerns. Specifically, the counselling of patients who have been exposed to hepatitis C through blood transfusion requires knowledge about the disease and experience of notification, pretest counselling, and support after the test. On the other hand, no new resources have been made available for this exercise. In many cases, general practitioners have indicated that they are inadequately equipped to deal with the task, and the burden has then fallen on the clinical staff at transfusion centres, who have the necessary skill and experience but no additional resources. Furthermore, the concentration of the workload on the transfusion centre can lead to disadvantages for the patient, who may have to travel long distances to meet an unknown clinician, who will be transmitting information that is bound to lead to anxiety and worry. In many circumstances this would best be done by a person who has knowledge of the patient and his or her medical history and personal circumstances.

A further concern is that many of the recipients who have been identified through the exercise are elderly. Not only are they unlikely to suffer any important consequences of hepatitis C infection, given the long time that symptoms take to develop, but they are the patients least likely to benefit from being transported to a site distant from their home to be interviewed by a person they have not met before and will never see again. There is no easy answer to this problem. In my experience of supervising a lookback exercise in two transfusion centres and involving close on 2000 blood components that must be traced through to recipients, discussion between the general practitioner and the clinician at the transfusion centre can often lead to a reasonable compromise that puts the patient's interests first.

The transfusion service has never advised that people who have received a transfusion and are not contacted through the exercise can be reassured. It has always been accepted that the exercise will be incomplete since hepatitis C is likely to have existed in the donor population throughout the 1980s, when tests were not available. Higson's solution, of offering testing for all recipients, would not produce complete results either. A considerable proportion of recipients are unaware that they have received a blood transfusion. These are usually patients who received the transfusion during surgery or emergency treatment. Furthermore, the fact that blood has been transfused is not necessarily noted in the hospital discharge letter. We have always advised general practitioners and concerned recipients that those who know that they have had a blood transfusion and are concerned about the possibility of hepatitis C can be fully reassured only by having a blood test. We should not pretend, however, that this will identify many more infected recipients than the targeted lookback programme currently in progress.

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