this anxiety can be substantially decreased by appropriate explanation[6] and may be less than the worry about the reason for the repeat smear test.

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Long term survival after intensive care

SIR,—Dr S Ridley and colleagues conclude that, in addition to severity of illness, age is an independent predictor of mortality of sufficient power to require an increase in the weighted values for this variable in the acute physiology and chronic health evaluation (APACHE) system.[1] They state correctly that their results may not be directly applicable to other intensive care units but suggest that age scores could form part of a reasoned admission policy. On superficial inspection this may seem self evident: the older and sicker the patient, the worse the prognosis.

The matter is, in fact, quite complex. Elderly people are more likely to have chronic diseases, and this effect should be separated from that of age per se by independent analysis of age and chronic disease history. Both of the studies that have done this showed that short term hospital survival is independent of age.[2,3] This is important because the study by Dr Ridley and colleagues was based in Glasgow and the patients form part of a population with one of the highest incidences of cardiovascular and smoking related diseases in the world.[4,5] Patients drawn from unhealthy populations may have reduced physiological reserve, making them "old before their time," which might explain the apparent need for additional weighting for age in west Scotland. Before we develop admission policies for elderly patients requiring intensive care we need measuring systems that allow us to distinguish between chronological and biological age.

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Sexual transmission of hepatitis C virus

SIR,—Dr J Tor and colleagues conclude that homosexual men and heterosexual partners of intravenous drug misusers in Barcelona have a low prevalence of hepatitis C virus and that "the rate of sexual transmission of hepatitis C virus seems to be low even in partners of people known to be seropositive."[1] These conclusions are based on a comparison with the prevalences of antibodies to HIV and hepatitis B virus in the same groups of people and on the use of an enzyme linked immunosorbent assay (ELISA) for hepatitis C virus antibodies, both of which may be misleading.

A better comparison would be with the prevalence of hepatitis C virus antibodies in other local groups less likely to be frequently sexually exposed. For instance, a recent study from Barcelona showed that of 1044 blood donors, 16 had antibodies to hepatitis C virus, a prevalence of 1·5%.[2] This contrasts with the findings of Dr Tor and colleagues of 16% prevalence in homosexuals and 11% in partners of drug misusers. With regard to transmission rates ELISA in its present form is inappropriate as a measure of infectivity because many people who are seropositive are either nonspecifically reactive or not currently infected.[3] A better basis for detecting rates of sexual transmission of hepatitis C virus would be amplification of serum complementary DNA by the polymerase chain reaction.[4] This might show that sexual transmission of hepatitis C virus is just as efficient as that of HIV and hepatitis B virus. Sexual intercourse may yet prove to be the main route by which hepatitis C virus is spread.

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4 Garson JA, Tedder RS, Briggs M, *et al*. Detection of hepatitis C viral sequences in blood donations by "nested" polymerase chain reaction and prediction of infectivity. *Lancet* 1990;**335**: 1419-22.

Clarke's legacy

SIR,—It is with dismay that I read yet again in your journal adverse comments about GP fundholding —namely Scrutator's remark that "a radical minister could readily extend and privatise NHS trusts and general practice fundholders."[1]

This is entirely consistent with the negative propaganda campaign currently being waged against fundholders in the *BMJ*. Does the writer of that article really believe that fundholders would be more easily privatised than any other self interested group of practitioners (as the profession showed itself to be when it failed to resign en masse at the imposition of the new contract).

I am unable to speak for NHS trusts but would assure Scrutator and any others who doubt the moral and ethical commitment of this potential fundholder to the NHS that my commitment is as deep as that of any of my non-fundholding colleagues. Furthermore, I am disappointed by the profession at large reiterating continually the short sighted and damaging comment passed at the last local medical committees conference: fundholding is detrimental to patient care. Fundholders have entered the scheme for many reasons, but one common theme is to improve patient care. When those improvements happen where will the rest of the profession be when it comes to taking up those improvements on behalf of the patient population if it continues to entrench itself in opposition to changes that an important minority of general practitioners see as one way forward to a better NHS?

Perhaps it is time for potential fundholders to come out of the woodwork and say who we are and why we are applying, and perhaps it is time for those who are sniping from behind pseudonyms and large conference bodies to state clearly their position and where they will stand when general practice fundholding is shown to work.

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1 Anonymous. Clarke's legacy of efficiency. *BMJ* 1990;**301**:1066. (10 November.)

Annual retention fees

SIR,—Scrutator reported the recent General Medical Council debate on the proposed increase in the annual retention fee. It may be of interest to your readers that the General Dental Council last week approved an increase in our annual retention fee from £37 to £50. (This also has to be submitted to the Privy Council as it is a statutory requirement for registered practice.)

Surprisingly, the increase was carried without either debate or question. I am sure that the reasons for the dental council's increase are broadly the same as those for the GMC's, and yet no passions were aroused despite the fact that next year is an election year for elected members of the dental council. Could it be that we have in the past been more successful in informing our profession of the benefits of self governing status and the dangers of losing this privilege, and that the dentists are consequently prepared to put their money where their mouths are?

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1 Anonymous. Dig deep in your pockets for the GMC. *BMJ* 1990;**301**:1120. (20 November.)

Information or advertisement?

SIR,—I wish to clarify the point I sought to make in the meeting of the General Medical Services Committee on 15 November, as reported by Miss Linda Beecham.[1]

My point was that the medical profession had not recognised the need to provide fuller information to patients and the public as a result of the Monopolies Commission's recommendations. We had increasingly recognised and publicised that need through both the BMA and the General Medical Council some years previously. We had also made a sharp distinction between information and promotional advertising, which the Monopolies Commission has implicitly acknowledged.

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1 Beecham L. Ethics committee's advertising proposals rejected. *BMJ* 1990;**301**:1220. (24 November.)

Monitoring surgeons' hours

SIR,—Scrutator mentioned some ill feeling on the subject of private practice being undertaken in NHS time.[1]

May I suggest that one way of throwing light on to this subject would be to undertake a detailed retrospective survey of the number of operations carried out by each surgeon, both in the private sector and in the NHS. A three month study of all surgeons in one English health region might at least provide some perspective that would help to illuminate the discussion.

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1 Anonymous. Clarke's legacy of inefficiency. *BMJ* 1990;**301**:1066. (10 November.)