there is such a level of apathy and indifference among BMA members?

As one who wishes to see a more vigorous, responsive, and successful BMA I suggest that greater use be made of the secret ballot at divisional meetings, and that rules be changed so that secret ballots can be held at the request of any member present. Any form of secret ballot, correctly used, could encourage a greater sense of participation and thus help to ensure the future success of our BMA.

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General practitioner outpatient referrals

SIR,—It is difficult to determine what constitutes an inappropriate outpatient referral; none the less I should like to support the premise of Dr G A Reynolds and colleagues[1] that increasing referrals to otolaryngology departments, which constitute 11-17% of National Health Service outpatient referrals,[2] are not explained by the increase in inappropriate referrals.

A study of new outpatient referrals to the North Riding Infirmary's otolaryngology department, which serves three districts in the Northern region, was undertaken to identify the proportion of referrals that could be classified as inappropriate. A total of 2200 referrals over similar two month periods in 1981 and 1989 were analysed after excluding cross boundary referrals or those without sufficient details—146 referrals (15%; 95% confidence interval 13% to 17%) and 162 referrals (11%; 9% to 13%) were excluded from analysis in 1981 and 1989 respectively. A newly referred patient in whom no otolaryngological disease was identified at the time of outpatient consultation and who received neither treatment nor underwent investigation was defined as an inappropriate referral. There was no intersample difference in the number of consultant otolaryngologists in the unit or in the demography of the catchment population.

The number of referrals seen increased by 60%, from 819 to 1381, and this was achieved partly by a 49% increase in the number of outpatient clinics. The proportion of referrals without otolaryngological disease was the same in both years—125 patients (15%; 12% to 18%) in 1981 and 180 patients (13%; 11% to 15%) in 1989. Of these referrals, 86% in both years did not undergo treatment or investigation.

In conclusion, a comparison between years with different otolaryngological outpatient referral rates fails to confirm that inappropriate referrals as defined are an important cause of the variation.

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1 Reynolds GA, Chitnis JG, Roland MO. General practitioner outpatient referrals: do good doctors refer more patients to hospital? *BMJ* 1991;**302**:1250-2. (25 May.)
2 Wilkin D, Smith A. Explaining variation in general practitioner referrals to hospital. *Fam Pract* 1987;**4**:160-9.

Cooperation between United Kingdom and Soviet Union

SIR,—Miss Luisa Dillner discussed the International Atomic Energy Agency's report on the effects of the nuclear disaster at Chernobyl.[1]

On 27 February this year a symposium on the treatment of acute leukaemia took place at the All Union Cancer Centre, the leading Soviet oncological institute in Moscow. Haematologists from the United Kingdom and the Soviet Union attended, and it became clear that the next step should be to set up an exchange programme to promote training.

The increase in cases of acute leukaemia after the Chernobyl disaster has emphasised the difficulties that already stretched Soviet workers have in applying sufficient resources. Under difficult circumstances haematologists in Moscow are endeavouring to treat their patients according to internationally accepted chemotherapy regimens. The problem could be eased, however, if Soviet colleagues could benefit in addition from the experience and resources of British doctors and facilities. Ideally, this exchange should be of not just medical staff but also nurses and other health care workers.

It is hoped that a programme will start shortly, with a two month exchange between a junior haematologist from the All Union Haematology Centre in Moscow and a haematologist from the Manchester area. We know that several medical links already exist between the United Kingdom and the Soviet Union, and we would be interested to hear from any other groups that would like to take part in this programme. Please contact Sheila Mehl, Oncology Project Manager, Farmitalia Carlo Erba Ltd, Italia House, 23 Grosvenor Road, St Albans, Hertfordshire AL1 3AW.

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1 Dillner L. Chernobyl's effects. *BMJ* 1991;**302**:1295. (1 June.)

Adequacy of general practitioners' premises for minor surgery

SIR,—The report by Messrs N Zoltie and G Hoult on facilities available for minor surgery in general practitioners' premises does not, in our view, address important aspects of controlling infection.[1] Three of the 42 practices were considered inadequate because of deficiencies in sterilising systems, and we are also informed that sterilisation by immersion was regarded as acceptable.

It is important to distinguish between the sterile instruments used to carry out invasive procedures and equipment required for non-invasive procedures, for which disinfection may be adequate.[2] Sterilisation is best achieved by a table top steam autoclave with regular calibration with a thermocouple to achieve the correct temperature. Immersion in chemical disinfectants is unlikely to render an item sterile and is best reserved for equipment that is heat labile. As sodium hypochlorite is too corrosive and glutaraldehyde unsafe to use except under strict conditions, chlorhexidine 0·5% in alcohol 70% is recommended. It is essential that instruments are completely submerged, the correct concentrations used, and solutions made up fresh before use. General cleaning with detergent and water before sterilisation or disinfection should not be underestimated as this significantly reduces the bacterial load.[3]

The safe disposal of clinical waste is critically important both in hospitals and in general practice. All clinical waste should be carefully bagged in coded yellow bags separate from general office waste and stored at a secure location before incineration or transfer to a central disposal unit. Discarded syringes, needles, broken ampoules, and other sharps should be placed directly into an approved sharps container, which should be sealed ready for collection and disposal after one week's use or when three quarters full. Such containers should never be filled to capacity as this increases the risk of needlestick injuries during use or when being sealed.

We believe that these measures serve the best interests of patients undergoing minor surgery and also contribute to safe practices, thus protecting all staff, both medical and non-medical.

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1 Zoltie N, Hoult G. Adequacy of general practitioners' premises for minor surgery. *BMJ* 1991;**302**:941-2. (20 April.)
2 Ayliffe GAJ, Collins BJ, Taylor LJ. *Hospital-acquired infection.* London: Wright, 1990.
3 Gardner JF, Peel MM. *Introduction to sterilization and disinfection.* Melbourne: Churchill Livingstone, 1986.

SIR,—Messrs N Zoltie and G Hoult assessed the adequacy of general practitioners' facilities for undertaking minor surgery in their family health services authority; on inspection they judged most of the practices as being satisfactory or near satisfactory.[1] As there are no central guidelines for criteria of acceptance standards for facilities, premises, and equipment were formulated locally. We disagree with the standards they set for assessing infection control procedures, in particular their acceptance of boiling water as a method of sterilisation.

All items used surgically must be sterile.[2] Boiling water cannot be relied on to kill bacterial spores and so is not a method of sterilisation. It gives sufficient decontamination for items in contact with intact mucous membrane but not for those that come into contact with sterile, or normally sterile, body tissues. We also disagree with their statement that "gloves were not considered necessary for sterility": sterile gloves are as essential for surgery as sterile instruments. They accepted controlled immersion in chemical disinfectants for sterilisation. This is most unlikely to result in sterility and is not recommended for use if other, more reliable, methods can be used.

General practitioners doing minor surgery must have access to sterile instruments. This can be achieved in three ways: by using a steriliser (steam or hot air) in the practice, by supply from a hospital's central sterile supply department; and by purchasing sterile single use items. One or more sources may be appropriate. Different options should be explored by each practice to satisfy its own requirements and are detailed in a code of practice published by the BMA.[3]

We believe that it is important for general practice to offer the same standards of control of infection as have been recommended for hospitals[4] and dental practices.[5]

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1 Zoltie N, Hoult G. Adequacy of general practitioners' premises for minor surgery. *BMJ* 1991;**302**:941-2. (20 April.)
2 Hoffman PN, Cooke EM, Larkin DP, *et al.* Control of infection in general practice: a survey and recommendations. *BMJ* 1988;**297**:34-6.