for our patients in renal failure should not be greater than our concern for other human beings, even if we are nephrologists or transplant surgeons.

Giving a fair price is not the solution for poverty. This is a worldwide problem. Opening such a door will add to the miseries of Third World countries as they would become the sole source of organs for sale.

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Deprivation indices

SIR,—Though we agree with the sentiment expressed by Professor B Jarman and colleagues concerning the importance of identifying areas of deprivation in order to help concentrate limited resources for health services in these areas, we disagree with their conclusion that further discussion of the differences among them is unlikely to be productive.[1] If it is important that deprived areas are identified then it is important that we are clear about what is being measured, and how and for what purpose, so that the most appropriate index or single variable is used.

The authors point out that the three indices under discussion intercorrelate highly (R=0·85). It would be surprising if they did not. What matters, though, is not the correlation in the distribution as a whole but the correlation in the extreme of the distribution at the deprived end.

In two neighbouring district health authorities, comprising 86 electoral wards, we looked at those wards defined as falling into the most deprived 10% on each of the Jarman and Townsend indices. This exercise identified a total of 13 wards, only five of which were common to both indices. The correlation for the distributions as a whole was not dissimilar to that found by the authors (R=0·721) in the wards used.

Resource implications can be considerable. Hutchinson *et al* estimated that appreciable differences in financial allocations to regions would result from the general practitioners' contract if deprivation was assessed with the Townsend rather than the Jarman index.[2]

The links between deprivation and ill health are no longer contested. Deprivation has established a place on the health care agenda. Further debate on the relation between measures of deprivation and ill health will improve understanding of the subject and should be encouraged.

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1 Jarman B, Townsend P, Carstairs V. Deprivation indices. *BMJ* 1991;**303**:523. (31 August.)
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Mandatory assessment of patients aged over 75

SIR,—Dr C M Clark undertook the mandatory assessment of patients aged over 75 in his practice conscientiously; sadly, his letter illustrates a failure to understand the importance of this part of the new contract. Until now, elderly people have been largely neglected in general practice for several reasons, such as lack of training, underdiagnosis, poor management, overprescribing, poor standards of record keeping, and rejection of the social dimension in health as alien.[2]

Although Dr Clark describes the assessment carried out in his practice as a "fruitless waste of skill and time," important needs were uncovered, but not those his training had led him to expect. There is a large increase in mortality and morbidity over the age of 75, so the finding of one new case of anaemia among 8700 patients clearly indicates a fault in delegating assessment to the nurse.

My own work has shown that it is necessary to abandon the old method of binary thinking, based on Morgagni's description of disease and the concept that one either has a disease or not.[3-6] My research showed that 86% of those aged over 70 have various combinations of eight conditions which are not of ecological but of internal origin, lying on a scale between apparent normality at one end and gross disturbance at the other. They develop insidiously through changes in the energy and adaptive homoeostats and are not to be thought of as multiple pathology so much as overlap, which requires the use of set theory for proper understanding. It is not, however, the presence of these conditions that matters so much as their speed of advance, and it is for this important reason that annual reassessment is required.

In conclusion, as eight patients required hearing tests, would Dr Clark not consider it reprehensible if there were eight children deafened by glue ear in his practice? Undoubtedly he would. It is time that the nihilistic attitude to elderly people was abandoned, to be replaced by enthusiasm at what can be achieved by general practitioners, especially those who examine their patients.

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American perspective on NHS reforms

SIR,—Professor Donald W Light's views on the government's NHS changes are interesting and welcome,[1] as are the thoughts of any outsider with no political, professional, or historical prejudices. But his conclusion that "The BMA, the royal colleges, and the politicians must decide soon to pass such a law" (one "to outlaw private insurance that competes with the NHS") shows some lack of understanding of what is possible in Britain.

Firstly, the British people, having seen the benefits of competition on state monopolies (the improvement in British Telecom since the advent of Mercury, although still not enough, has been remarkable), would not tolerate such legislation. They might, indeed, look to eastern Europe, where citizens demonstrated in the streets in favour of just the opposite. And, secondly, we have not—mercifully—reached a stage where the BMA, or even the royal colleges, decide to pass a law.

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1 Light DW. Observations on the NHS reforms: an American perspective. *BMJ* 1991;**303**:568-71. (7 September.)

SIR,—It was refreshing to read an American critique of the NHS reforms in Professor Donald W Light's paper.[1] While agreeing with his observations on the insidious development of a two tier system in Britain, I feel that his solution to this—namely, the outlawing of private insurance that competes with the NHS—might well produce more problems than it solves. We need to explore ways in which the majority of consultants can be encouraged to become contracted fully to the NHS. Most are already working hours far in excess of those for which they are remunerated. Nevertheless, while the present arrangements continue the profession can hardly claim to be opposed to a two tier system.

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1 Light DW. Observations on the NHS reforms: an American perspective. *BMJ* 1991;**303**:568-70. (7 September.)

Set menus and clinical freedom

SIR,—We welcome Drs T C O'Dowd and A D Wilson's article on clinical guidelines[1] and would like to make some additional points.

The United States has longer experience with clinical guidelines than does the United Kingdom, and a recent editorial from the United States identified the following problems.[2] Guidelines are clumsy, for each patient is unique. Guidelines may be out of date by the time they are released. Clinicians may incur malpractice liability if they do not follow guidelines. Guidelines that limit usual practice may disappoint patients; those that call for more care may disturb budget makers. Guidelines can provoke contention between doctors, and they can undermine the physician's sense of belonging to a profession. If clinical guidelines are to find their proper place in the practice of medicine the problems listed above have to be carefully thought through.

Drs O'Dowd and Wilson recognise the phenomenon of clinical trial results failing to influence clinical practice. Our experience is that the language of clinical epidemiology (predictive values, risks, and odds) is very different from the narrative mode of the consultation which we, as clinicians, work with.

It has been known in theory for some time[3] and now has been shown clearly in practice[4] that a guideline derived in one clinical setting does not necessarily apply in a different clinical setting. General practice has always been vulnerable to advice and guidelines derived from secondary and tertiary care being put forward for use in primary care. It is essential that future guidelines have sufficient input from primary care to make them both relevant and rigorous.[5] For a discipline whose content is characterised by its very lack of boundaries—such that a working definition could be "any problem, any person, anytime"—the challenge for general practitioners will be as much to know when not to use clinical guidelines, with their inherent inflexibility, as to know when they need to be implemented.

We are concerned that guidelines can provide a falsely reassuring impression of certainty for both the doctor and the patient. General practice is to do with managing uncertainty, with diagnosis being a matter of probability, not certainty.[6] Guidelines may contribute to the misrepresentative scientistic view of medicine as being about exactness, certainty, and the elimination of doubt, whereas medicine should be based on the science of measured doubt.[7]

Finally, will following guidelines do the patient any good? In a review of 33 papers on clinical prediction rules Wasson and colleagues found only two of the papers had looked at the clinical outcome of using such rules.[8] If clinical guidelines

are to be widely adopted then their effects on patient outcome have to be evaluated.

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Nursing: an intellectual activity

SIR,—From a viewpoint in the so called underdeveloped world, Professor June Clark's editorial on nursing looks archaic.[1] The nursing profession, and British nursing academe, could learn a great deal by looking at what nurses are actually doing worldwide. In Vanuatu nurses have for perhaps a hundred years been fulfilling what Professor Clark advocates—and continue to do so with a good deal of jargon free common sense. Nurses here have the roles of the British general medical practitioner, social worker, junior (or senior) hospital doctor, or hospital administrator, to mention a few areas. Shortage of doctors may be the superficial reason for this arrangement, but it contains fundamental lessons for the developed world, not least being the roles of doctors and nurses.

As in most parts of the "underdeveloped" world it is normal, for instance, for nurses in our hospital to do family planning counselling, give a safe general anaesthetic, perform a tubal ligation (or teach a young doctor how to perform the operation), with all documentation by the nurse. This is in addition to what might be regarded as normal hospital nursing activity in the United Kingdom. Community nursing involves a similar range of responsibility.

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1 Clark J. Nursing: an intellectual activity. *BMJ* 1991;**303**:376-7. (17 August.)

SIR,—The four respondents to Professor Clark's editorial[1] all seemed unduly upset by the idea of an academic analysis of nursing.[2]

Because many experienced nurses seem to be excellent at many aspects of their job does not mean that the nursing process does not deserve serious academic study. The existence of academics does not mean that every nurse must use academic jargon—presumably those who study the nursing process will make their conclusions known so that they can be applied in the places of work and study. It seems that academic study is being applied to professions as diverse as general practice and the police force. Most of us can no longer get away with flying by the seat of our pants.

You cannot have it both ways. Professor S Brandon's perception of an increase in the incidence of bed sores and Dr Sally-Ann Hayward's concern at an apparent lack of emotional support supplied by nurses are both presented as speculation, unsupported by evidence and references. The very process they decry—academic study—is the only way of examining these and other hypotheses so that proper conclusions can be drawn and action taken.

Could the spectre of analytical and more professional nurses be somewhat threatening?

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1 Clark J. Nursing: an intellectual activity. *BMJ* 1991;**303**:376-7. (17 August.)
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Payment for drugs

SIR,—I believed regulation 29B(b) entitled a general practitioner to payment for drugs given to patients in an emergency, but this is clearly not the case as almost every general practitioner claims for vaccines given by the nurse while the costs of other drugs genuinely needed by a doctor in the acute situation are not reimbursable under paragraph 44.5.

Doctors can claim payment for the injections and sutures used in minor operations but cannot claim for the sterilising solutions and dressings clearly needed for minor surgery procedures. The prescription pricing authority informed me that I am obliged to issue my patients with a prescription for their dressing pack and chlorhexidine sachets. They also informed me that "the practice allowance . . . includes an element to offset the cost of other appliances, dressings, etc . . . and hence no further payment can be claimed."

This hardly encourages the prescribing general practitioner to hold a comprehensive stock of drugs, dressings, and appliances (such as urinary catheters) that patients might need in an emergency, and I imagine few doctors willingly subsidise their patients for the full cost of such items readily obtainable from a chemist on the NHS; I take it that I must therefore prescribe salbutamol nebules for the 16 year old girl in status asthmaticus to "obtain from the chemist of her choice in the usual way" and that the child in status epilecticus must first obtain his rediazepam from the pharmacy. Rather than attempting to provide an appropriate acute medical service it is clearly far easier for prescribing doctors to rely on the hospital.

As an immediate care doctor I am dismayed that our equipment must be provided by charity, but I fail to understand why NHS general practitioners cannot claim payment for those medicines that are prescribable on an FP10 and dispensed in an emergency.

As is happening elsewhere, the Lothian health board intends to close the accident and emergency department of the Western General Hospital, Edinburgh, leaving the local general practitioners to cope with the 25 000 minor injuries treated there each year. These general practitioners feel unable to provide an appropriate service because of the considerable limitations of paragraph 44.5. Most rural general practitioners, however, willingly provide a comprehensive minor accident service because as dispensing doctors they have immediate access to the tools for the job.

Much has changed in the 78 years since the 1913 act removed dispensing from the doctor's surgery—the advent of information technology, indicative prescribing amounts, and prescribing analysis and cost (PACT) data have eliminated the risks of abuse. The return of universal dispensing is a certain way of encouraging the general practitioner's role in minor surgery, minor accident care, and all aspects of acute medicine, but perhaps this could more easily be achieved by expanding the items listed for payment under paragraph 44.5.

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Fellowship of the RCGP by assessment

SIR,—Dr Fiona Godlee's article on the membership examination of the Royal College of General Practitioners referred to the fellowship of the college. Since July 1989 this college has introduced a second and new route to fellowship based on the care of patients in general practice. This radical development opens the possibility of fellowship to every member of the college of five years' standing who is in active practice. It is based on open, published clinical standards of care for patients. The route is voluntary and the timing flexible and entirely at the doctor's own discretion. Some have already completed it at a few months' notice; others are working slowly towards it over many years.

The theoretical aspects of this development illustrate the role of a college that has in its royal charter the words "to encourage, foster, and maintain the highest possible standards of general medical practice." This is an interesting example of peer review in action as all the three assessors, who visit the practice, are true peers—that is, fellows of the college themselves. The problem of fixed and therefore dated standards has been overcome by establishing a working group to keep them continually under review in the light of new research and advancing clinical practice and by requiring the council of the college to give formal approval of all additions annually.

The portents suggest a fundamental change in the approach to both clinical standards and medical education.[2] Clinical standards in the broadest branch of clinical practice have been defined at the highest possible standard. This is a highly educational exercise, and many regional advisers recognise the visits as educational events for the postgraduate educational allowance. Other partners benefit from the tightening up of systems in the practice. Nine general practitioners in Britain have so far succeeded in reaching this standard, but a substantial increase in numbers can be expected.

It remains to be seen if this approach to fellowship will be followed by other medical royal colleges in the United Kingdom or by colleges abroad.

The history of fellowship of the college by assessment with a list of the original criteria and the research work that influenced them has now been published.[3]

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Followed to the letter

SIR,—For those who, like Dr John Doherty,[1] dislike letters annotated "dictated but not signed" might I suggest the expedient of returning the offending letter marked "opened but not read"?

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1 Doherty J. Followed to the letter. *BMJ* 1991;**303**:722. (21 September.)