

(as well as the World Health Organisation) should strongly condemn the sanctions, and demand the lifting of the embargo on medicines and food for Cuba.

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Auditing the *BMJ*

EDITOR,—Richard Smith's editorial at the beginning of the year on auditing the *BMJ* dealt only with the process of publishing and not with its outcome.¹ The aim of publishing original research may be to educate but must also be to change practice for the better.² I have audited volume 296 (1988) of the *BMJ* to see what impact published original research had on clinical practice in my institution.

All the original papers and short reports were read and classified as descriptive or practical. A practical paper was defined as one in which the paper's conclusion recommended a change in practice as a result of the work it described. All the practical papers were reviewed by one of a panel of 18 consultants in teaching hospitals and two general practitioners with skill in the subject of the paper. Members of the panel were asked if change in practice recommended by the articles in 1988 had now, in their opinion, become current practice.

Of the 169 main papers and 140 short reports, only 14 (8%) and nine (6%) respectively were entirely practical; a further 30 (18%) and 30 (21%) had a practical element. Most (59) of these papers were relevant to hospital specialists, with only eight being directly relevant to general practitioners. The specialist reviewers believed that the change in practice advocated in 37 of the 83 papers had now become established. Thus a change of practice has followed the publication of nearly half of the papers that recommended change. Overall, however, because most of the papers were descriptive only about one tenth of the original papers and short reports published by the *BMJ* in 1988 have influenced current clinical practice in 1993.

This kind of survey cannot address the mechanism of change, and I do not infer that a single paper can cause a major change, except on rare occasions—for example, the paper that described the second international study of infarct survival. Nevertheless, if one aim of publishing original research is to change practice then an editorial policy which encourages the publication of papers with a practical element should be considered since these have greater potential to influence practice.

The *BMJ* is the most widely distributed medical journal in Britain and receives nearly 5000 original papers a year. It is therefore uniquely placed to advocate changes in clinical practice.

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- 1 Smith R. Auditing *BMJ* decision making. *BMJ* 1993;306:3-4. (2 January.)
- 2 Lundberg GD, Williams E. Quality of a medical article. *JAMA* 1991;265:1161-2.

Accident and emergency in London

EDITOR,—We agree with D J Harborne and J Worrell that the use of broad diagnostic groups is not the most sensitive method for comparing the appropriateness of attendance at accident and emergency departments,¹ but our study did not aim to show this.² Accident and emergency departments, like general practitioners, have to deal with a broad range of presenting complaints and un-

certainly of diagnosis. This makes the International Classification of Primary Care preferable to the ICD.³ Neither coding system, however, incorporates indices of severity which would help decide whether attendance is appropriate.

Harborne and Worrell note that higher proportions of patients with gastrointestinal, respiratory, urological, and psychological conditions attended the inner London hospital in our study. These differences would account for only 2912 extra new attendances annually (4.6% of the total) at this department. Even assuming that all these extra cases could have been dealt with more appropriately in general practice, this does not confirm that "the quality and availability of primary care makes an enormous difference" as suggested by Harborne and Worrell.

Patients who attended with the specific diagnoses Harborne and Worrell thought were important (acute otitis media, upper respiratory tract infection, and urinary tract infection) totalled 39/1317 (3%) in inner London and 16/1384 (1%) outside London. The numerical difference is small and is partly explained by these conditions being seen more in people who had moved in the past three months or who were tourists or commuters. Similar proportions of patients with these diagnoses were admitted in inner London 3/39 (8%) and 1/16 (6%) outside London, which suggests that the complaints were of similar severity in the two hospitals.

Our conclusion was that sociodemographic factors are more important in determining the difference in workload between the inner London and outside London hospitals than major differences in clinical case mix or the quality of general practice.² As C W I Owens and colleagues suggest, changes in general practice are unlikely to alter substantially the consultation patterns of the tourists, commuters, homeless people, and mobile populations in inner London.⁴ Other options for improving access to primary health care for these groups should be considered.

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- 2 Jankowski RJ, Mandalia S. Comparison of attendance and emergency admission patterns at accident and emergency departments in and out of London. *BMJ* 1993;306:1241-3. (8 May.)
- 3 Lamberts H, Wood M. *ICPC international classification of primary care*. Oxford: Oxford Medical Publications, 1987.
- 4 Owens CWI, Ben-Shlomo Y, Moore F. Accident and emergency in London. *BMJ* 1993;306:1751. (26 June.)

Child health surveillance

EDITOR,—Doctors working in primary care in deprived areas will not be surprised that Jacqueline Gregg and colleagues found that inadequate resources had prevented inner city practices from introducing child health surveillance.¹ Evidence is accumulating that preventive child health services in such areas may need to take a different approach from that taken in more affluent areas.

In 1990 the Association of General Practice in Urban Deprived Areas expressed concern about the pressure for general practice to provide all preventive services.² It believed that this model would not meet the needs of patients in urban deprived areas. More recently the Joint Working Party on Medical Services for Children has also stated that practices in deprived areas are less likely to provide preventive services. Further evidence is available from a deprived area in South Sefton, a health district adjacent to Liverpool that has many of the problems outlined by Gregg and colleagues. In one deprived area only 34% of children were immunised by general practitioners and 16%

attended general practitioners for child health surveillance in 1991 despite the incentives in the new contract.

A comparison of the needs of NHS regions showed that primary care was understaffed in deprived areas.³ Consultation rates in Mersey region are significantly higher in its urban areas,⁴ with inner Liverpool having the highest rate of all.

Statistics on the use of services are not enough to assess needs in deprived areas. Comparing morbidity at school entry with the percentage of those problems not identified before school entry is one way of assessing the health needs of preschool children. This approach was used successfully in the area in South Sefton described above⁵ and is now being used on a much wider scale in Northampton. Such information will assist planning of services at local and national levels.

General practitioners in deprived areas are likely to need the continuing support of community child health doctors to provide effective health care for children. Both groups should improve their communication, with community child health doctors linked to, or working in, practices. This idea is not new: the Court committee recommended it in 1976.

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- 2 Association of General Practitioners in Urban Deprived Areas. *Deprived areas and change in the NHS*. London: AGUDA, 1990.
- 3 Birch S, Maynard A. Regional distribution of family practitioner services: implications for National Health Service equity and efficiency. *J R Coll Gen Pract* 1987;37:537-9.
- 4 Merseyside and North Wales Faculty of the Royal College of General Practitioners. *A study of morbidity in Mersey region 1981-1982*. Liverpool: Merseyside and North Wales Faculty of RCGP, 1987.
- 5 Ni Bhrolchain CM. Routine or selective school entry medicals: a review of current literature. *Public Health* 1993;107:37-43.

Temazepam tablets as drugs of misuse

EDITOR,—E J Vella and C W Edwards report on a patient who died after injection of temazepam tablets.¹ Last year I became concerned about a promotional campaign that had been launched by Norton Healthcare; it emphasised the advantages of prescribing temazepam tablets as a way of preventing the intravenous injection of temazepam by drug misusers. Leaflets sent to general practitioners and pharmacists were headed "Hard to push. Easy to prescribe," and the message was driven home by the inclusion, as a promotional gimmick, of a plastic syringe blocked up with temazepam tablets.

The literature claimed that the formulation "makes it very difficult for drug users to extract the active ingredient for injection." I did not believe that this claim was true: within 45 seconds of being mixed with warm water in the barrel of a 5 ml syringe that is shaken gently a 20 mg temazepam tablet turns into a fine suspension, which can easily be injected through a standard gauge needle. When I wrote to the manufacturer expressing my anxieties it replied that this was not a problem since the supernatant fluid contained so little active temazepam. I could not see the relevance of this comment, since what was often injected was not the supernatant fluid but the whole preparation.

I believe that temazepam tablets are injected quite often. Recently, self report questionnaires on use of temazepam have been left in the waiting area to be filled out by drug users waiting for appointments with Trafford community drug team. Sixty questionnaires have been completed. In this sample nine users admitted having injected temazepam tablets occasionally. Twenty eight users claimed that they knew people who had