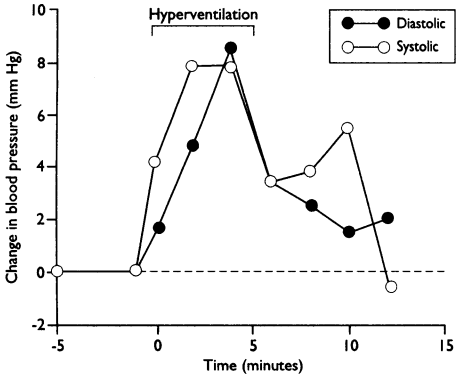

Effect of five minutes' hyperventilation on blood pressure of 26 normal subjects

subjects by 8-9 mm Hg.[5] Perhaps forced hyperventilation should be used with caution in those with hypertension or, indeed, any cardiovascular disease.

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1 Tantam D. Any questions. *BMJ* 1993;307:440. (14 August.)
2 Yasue H, Nagoa M, Omote S, Takizawa T, Tanaka S. Coronary arterial spasm and Prinzmetal's variant form of angina induced by hyperventilation and TRIS-buffer infusion. *Circulation* 1978;58:56-62.
3 Freeman LJ, Nixon PGF. Are coronary artery spasm and progressive damage to the heart associated with hyperventilation syndrome? *BMJ* 1985;291:851-2.
4 Roll M, Zetterquist S. Acute chest pain without obvious organic cause before the age of 40 years: response to forced hyperventilation. *J Int Med* 1990;228:223-8.
5 Todd GT, Chadwick IG, Ramsay LE, Yeo WW, Jackson PR. Pressor effect of hyperventilation in healthy subjects. *J Hypertens* (in press).

Distribution of mental health professionals in primary care

EDITOR,—In highlighting the patchy distribution of mental health professionals Tony Kendrick and colleagues show the extent to which mental health professionals have been diverted into general practice.[1] Although more than half of the practices surveyed had at least one such professional on site, the impression given was of different combinations of staff working in different ways in different practices. Despite epidemiological research that has firmly established that the largest proportion of psychiatric morbidity in the community presents to, and is manged by, general practitioners, there is little evidence to support the efficacy of specific psychiatric interventions in general practice. Apart from the finding that moving psychiatric outpatient clinics into general practice reduces demand on secondary care services,[2] the evidence for other types of intervention has been equivocal.[3] Preliminary findings from Manchester suggest that basing entire mental health teams in general practice may encourage general practitioners to refer patients whom they might otherwise have managed themselves.[4]

The recent trend towards providing mental health care in the community has highlighted tension between the needs of primary care staff, who deal with large numbers of patients presenting with the common non-psychotic illnesses, and secondary care teams, which have traditionally assumed responsibility for those with chronic psychotic disorders. The internal market has shifted the balance of power in general practitioners' favour: previously dependent on secondary care teams for psychiatric services, fundholding practices can now purchase services and even employ their own mental health professionals.[5] In the absence of empirical evidence to guide clinical practice such reforms are likely to distort the distribution of staff further. Kendrick and colleagues' study would have been even more enlightening had it inquired into the nature of the psychiatric disorder being treated and which of the mental health staff in question were employed by the practices.

Although mental health professionals find the experience of working in general practice highly rewarding, this is insufficient to justify the current deployment of staff. Further research is urgently needed to elucidate which combinations of patients, interventions, professionals, and settings represent the most cost effective use of resources.

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1 Kendrick T, Sibbald B, Addington-Hall J, Brennerman D, Freeling P. Distribution of mental health professionals working on site in English and Welsh general practices. *BMJ* 1993;307:544-6. (28 August.)
2 Tyrer P, Seivewright N, Wollerton P. General practice psychiatric clinics. Impact on psychiatric services. *Br J Psychiatry* 1984;145:15-9.
3 Scott AIF, Freeman CPL. Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;304:883-7.
4 Jackson G, Gater R, Goldberg D, Tantain D, Loftus L, Taylor H. A new community mental health team based in primary care. A description of the service and its effect on service use in the first year. *Br J Psychiatry* 1993;162:375-84.
5 Thomas RVR. Psychiatrists in the new NHS. *BMJ* 1992;305:834-5.

Protecting the public

EDITOR,—Stuart Handysides reports that the General Medical Council has disciplined Dr B S Irani for serious professional misconduct; he reports the president of the council as recommending that "all employing authorities should review their procedures for appointing locums."[1] In the summer of 1990, on behalf of Lancaster Community Health Council, I produced a report on another locum, in this instance an obstetrician, who had been removed from the register by the General Medical Council in July 1989 while she was temporarily employed in Lancaster. The offence leading to her removal had taken place 17 months earlier in Scunthorpe. In the intervening months she had fulfilled a continuous series of short appointments. None of her employing authorities knew of the General Medical Council's impending hearing.

We found that there were no mechanisms by which information about unsatisfactory conduct, whether leading to action by the General Medical Council or not, would automatically be made known to subsequent employers. Because of the proliferation of short term engagements and frequent booking of locums months in advance, references could easily fail to alert employers to problems. We also found that there was no simple way of tracking down the current whereabouts of any doctor regularly doing locum work. In our report we suggested some possible remedies, primarily concerned with the supply of relevant information to potential employers; these included a central information bank on the whereabouts and status of doctors and a requirement that applicants taking up posts should declare any impending investigations.

We sent our report to all the bodies we thought appropriate, including the General Medical Council, NHS Management Executive, Royal College of Surgeons, Royal College of Physicians, and parliamentary select committee on health. In reply, each agreed that the problem needed to be addressed. What I cannot understand is how Sir Robert Kilpatrick can now wring his hands over the case of Dr Irani three years after we alerted him to the problem, which, by all accounts, was already a widely recognised cause for concern. Duncan Nichol, the chief executive of the NHS Management Executive, replied: "Officials here will be discussing the case and the wider issues it raises with NHS managers. The problems it highlights relating to the recruitment and quality of locums will not be easily resolved but must be addressed." Sadly, none of the bodies that replied to us seems to have done anything.

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1 Handysides S. Deplorable case prompts warning to British doctors. *BMJ* 1993;307:222. (24 July.)

Regulation of locum staff

EDITOR,—D J Dye's suggestions to prevent professional misconduct by locum staff are far too complicated and would need a lot of expensive bureaucracy to work in daily practice, if they would work at all.[1] Dye suggests a central computerised register for locum staff and a bound log book stamped by each employer. Much easier would be a different system of references. In Britain employees (in this case doctors) do not know what kind of reference their former employer (consultant) will give them, and their next employer will always get to know only the references that they provide. I have worked in Britain for several years and have seen the differences between the British and German systems of job applications and references.

In Germany every employee gets a testimonial (certificate) from his or her employer on leaving a job. This testimonial describes qualifications, behaviour, abilities, and more. On applying to work elsewhere employees have to produce all testimonials from their previous employers for their potential new employer (they "collect" several certificates during their working life). This system enables the new employer to have a complete overview of the previous abilities of the potential new employee, and the employee is not able to deny any previous misconduct. It also enables the employee to have a written overview of his or her career, referees, and qualifications. In special cases it is still possible for the new employer to get in personal contact with previous referees.

I regard this German system as much fairer and easier for both the employee (doctor) and the employer (consultant and hospital).

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1 Dye DJ. Regulation of locum staff. *BMJ* 1993;307:449-50. (14 August.)

Complaints procedures

EDITOR,—I strongly support the sentiments expressed by L Alan Ruben in his letter on complaints procedures.[1] My friend and colleague Dr David Pearson took his own life in March after receiving a complaint concerning the death of a patient. All my attempts to reassure him that he had acted correctly and should not be held to blame for his patient's death were in vain. I felt confident that, were he to be called before the service committee, he would be cleared. Nevertheless, his anxiety and distress were so great that suicide seemed to him his sole resort. I have since fought for improvements in the management of complaints, and I hope that evidence that I have