secondary to primary care. Psychiatrists must realise this and start taking the criticisms of their clients and clients to be, the general practitioners in their area, more seriously than they do at present.

This question needs to be addressed: if fundholding general practitioners are given the choice between a hospital oriented psychiatry service and other, equally effective, services that may be cheaper and are more flexible, how long before they start putting psychiatrists out of work?

RICHARD THOMAS

Section of Epidemiology and General Practice,
Institute of Psychiatry,
London SE5 8AF

1 Department of Health. Press release H92/242, 23 July 1992.
2 Wilkinson G. I don't want you to see a psychiatrist. *BMJ* 1988;**297**:1144-5.
3 Scott AIF, Freeman PL. Edinburgh primary care and depression study: treatment outcome, patient satisfaction, and cost after 16 weeks. *BMJ* 1992;**304**:883-7.
4 Balestrieri M, Williams P, Wilkinson G. Specialist mental health treatment in general practice: a meta-analysis. *Psychol Med* 1988;18:711-7.
5 Shepherd M. Who should treat mental disorders? *Lancet* 1982;i: 1173-5.

Reaccrediting general practice

EDITOR,—I believe that Denis Pereira Gray is wrong in his assumption that the profession has given a mandate to its leaders regarding reaccreditation. It is my opinion that he has falsely misinterpreted certain answers on the questionnaire *Your Choices for the Future*. The fact that two thirds of general practitioners disagreed with the statement "Once a GP has acquired a basic level of competence no further form of reappraisal is necessary during the rest of his/her active professional life" does not mean that two thirds of general practitioner's want a formal system of reaccreditation. Nor do general practitioner's actively want peer review; they simply want re-examination less.

Our performance as general practitioners is already more closely monitored than are most other branches of our profession or most people in other professions. We are all ultimately accountable to the General Medical Council for our professional conduct and standards.

We are accountable to the family health services authority, which monitors our standards (hours of availability, competence to practice minor surgery, paediatric surveillance, etc); they monitor our practice premises and our attendance at continuing education course to the equivalent of five full days a year. If we fail to meet standards, patients may have recourse to the law and, unique to general practice, yet another tier of monitoring by the family health services authority's complaints procedure. In most areas medical audit advisory groups visit practices, encouraging audit and reporting back to the family health services authority.

Those who are trainers have regular reapproval visits, written assessments by the trainee, and visits from trainers and occasionally the Joint Committee for Postgraduate Training. Pereira Gray puts forward the joint committee as a model of a reaccreditation system. Many colleagues have variously described its visits as being unpleasant, unhelpful, and unwelcome.

Finally, we are monitored by our patients, who consult the general practitioner who most suits their needs.

It is my opinion that we are already the most carefully scrutinised and monitored of all professions. Instead of fashioning yet more sticks with which to beat ourselves, we should wait for dentists, lawyers, accountants, etc, to catch us up. I believe that the majority of general practitioners do not want reaccreditation and that certain leading lights of the royal college are simply using this as a means of gaining more control over this profession. I urge my colleagues to reject compulsory reaccreditation.

JOHN RUSSELL

Burgoyne Medical Centre,
Sheffield S6 3QB

1 Pereira Gray D. Reaccrediting general practice. *BMJ* 1992;**305**: 488-9. (29 August.)

EDITOR,—There are three points I would like to make on Denis Pereira Gray's article on reaccreditation.[1]

Reaccreditation in the wrong hands would be a perfect opportunity for an aggressive, well connected minority to impose its view of general practice on the majority. The new contract was a perfect example of this. The whole profession would have to be consulted, rather than leaving it to members of the General Medical Services Committee, the Royal College of General Practitioners, and university postgraduate departments.

Any implication of unsatisfactory performance would be used by the Department of Health as a financial exercise. Look at "health promotion"—an idea of dubious clinical value, but a perfect vehicle for cutting costs.

The clear message contained in *Your Choices for the Future* was not the desire for reaccreditation but the need to change our absurd system of working.

What most of us need are conditions of service that enable us to practice our skills efficiently, not more sources of anxiety. Unfortunately, we are likely to get reaccreditation before reorganisation.

CHRIS NANCOLLAS

Yorkley,
Gloucestershire GL15 4TX

1 Pereira Gray D. Reaccrediting general practice. *BMJ* 1992;**305**: 488-9. (29 August.)

The Health of the Nation

EDITOR,—There are statistical difficulties (owing to the small numbers involved) inherent in the direct translation to district level of many of the targets contained in *The Health of the Nation*.[1] Nevertheless, because the data used to calculate the rates quoted are available routinely, districts may use the white paper indicators in descriptions of the health status of their populations. This is not, however, straightforward for some of the indicators—for example, in calculating teenage conception rates.

Using routine birth and abortion statistics, the calculation of the national numerator in *The Health of the Nation* is based on the assumption that, on average, a pregnancy lasts 38 weeks (Office of Population Censuses and Surveys, personal communication). Age of the mother at conception is calculated by subtraction from the date of birth and comparison with the mother's date of birth. These data are available for regions, but not at district level, where information is routinely presented only by age of the woman at the time of birth or termination of pregnancy. Simply adding together the number of births and abortions for those aged under 16 substantially underestimates the number of conceptions, since many of those who conceive aged 15 will be 16 when they give birth. An approximation to the true number of conceptions may be obtained by including, in addition to all those who gave birth aged under 16, 73% (38/52) of those who gave birth aged 16. The other difficulty is in calculating the denominator (girls aged 13-15 years) where, at district level, another approximation must be used—namely, application of the proportion of girls aged 13-15 nationally to the district estimate of population in five year age bands.

We hope that this information will be helpful to others who are involved in developing district responses to *The Health of the Nation*. We should like to strenuously endorse John Gabbay's plea for national initiatives to aid the development of appropriate local target measures for *The Health of the Nation* priority areas and the epidemiological information systems to go with them.[2] In the meantime, to prevent a laborious reinvention of the wheel the routine availability at district level of the rates derived by the Office of Population Censuses and Surveys that were used in the white paper would be most helpful.

SUE IBBOTSON

Department of Public Health,
Hull Health Authority,
Hull HU2 8TD

PAUL WATSON

Department of Public Health Medicine,
Airedale Health Authority,
Keighley BD20 6TD

1 Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992. (Cm 1986),
2 Gabbay J. The health of the nation: seize the opportunity. *BMJ* 1992;**305**:129-130. (18 July.)

AIDS: guidelines for barbers

EDITOR,—In answering a question about the risks of acquiring infections from barbers' equipment Alan Scott suggests that there is a theoretical risk of transmission of bloodborne infection but no documented episodes.[1] There has been at least one report, however, of transmission of hepatitis B virus associated with sharing razors within a household[2] and several documented cases of hepatitis B infection after parenteral exposure during acupuncture and tattooing.

Scott quotes a booklet published by the Department of Health and Social Security which recommended that hairdressers and barbers should use razors with disposable blades and change the blade for every customer.[3] My experience suggests that this recommendation has not been taken up and barbers do not change the blade between customers. *The Health of the Nation* identified HIV and AIDS as one of five key areas for action and prevention[4]; if an effort is to be made in this we should not only campaign for safer sex and to prevent needle sharing among drug addicts, but other types of percutaneous exposure should be targeted. The risk from malpractice in barbers' shops may be modest, but tightening up practice would be easy and is long overdue.

GIUSEPPE BIGNARDI

Harrow,
Middlesex HA1 3BG

1 Scott A. Any questions. *BMJ* 1992;**305**:566. (5 September.)
2 Goh KT, Ding JL, Monteiro EH, Oon CJ. Hepatitis B infection in households of acute cases. *J Epidemiol Community Health* 1985;**39**:123-8.
3 Department of Health and Social Security. *AIDS: guidelines for hairdressers and barbers*. London: DHSS, 1987.
4 Department of Health. *The health of the nation*. London: HMSO, 1992.

Corrections

Oesophageal atresia mistaken for anorexia nervosa

Owing to an editorial error the title given to the letters by James McSherry and by K M Pagliero (5 September, p 583) was incorrect. The title should have been "Oesophageal achalasia mistaken for anorexia nervosa."

Cardiac rehabilitation programmes

In the third paragraph of this letter by J T Scanlon and S Godfrey (12 September, pp 649-50) the number of women who underwent an exercise test should have been 19% (not 9%); this was a printers' error.