especially in rural areas. Doctors are pressed to require compensation from their patients, who can hardly afford to pay it. The salary of a doctor amounts to $US2 a month, so who can blame them? Obviously the state cannot sustain the 66 000 doctors, and many of them have become unemployed over the past two years. With one doctor per 170 inhabitants, Georgia has about the highest ratio of doctors to patients in the world.

The Ministry of Health has no hard currency to buy drugs: the shelves are filled with drugs from humanitarian relief agencies. Defining the quantities of drugs needed is difficult since previous consumption of drugs is not a good criterion for defining present needs in a system that is hospital based and where overprescription is the rule. Not all health staff are familiar with the generic names of pharmaceutical products used in the West, so distribution of drugs is not just a matter of supply. The recipients need information and training if they are to make correct decisions on drug treatment.

The national immunisation programme has collapsed. The supply of vaccine from Russia has stopped, and already small outbreaks of diphtheria and measles have been reported. To start up an immunisation programme again, antigens from Russia will have to be replaced with others and a new programme will have to be introduced, for which thorough training will be necessary.

There is no solution to Georgia's health problems without economic recovery and health reform.

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Arbitration in medicolegal disputes

EDITOR,—Malcolm Forsythe's editorial on arbitration and the internal market is a useful contribution to the growing debate on the resolution of disputes in medicine.[1] Though arbitration undoubtedly offers a viable alternative to litigation in medicolegal disputes, however, it is not the only alternative but is part of a range of techniques encompassed by the term "alternative dispute resolution." The other main technique is mediation, which differs from arbitration in several important respects: the proceedings are without prejudice and confidential, and any resolution is arrived at by the disputants themselves and not imposed by the neutral mediator. If agreement is reached it is not legally binding on the parties, but this is not necessarily a weakness of the process. The advantages of mediation in medicolegal disputes are speed, low cost, a reduction of stress on both parties, and the likelihood of resolution satisfactory to both sides.

The use of alternative dispute resolution in commercial disputes is now well established in Britain, largely owing to the efforts of the Centre for Dispute Resolution. This centre was set up in 1990 with the support of the Confederation of British Industry. The first one day conference on alternative dispute resolution in medicine was held at the Royal Society of Medicine last December under the joint auspices of the Institute of Arbitrators and the BMA and was entitled "Disputes between patient and doctor. Is arbitration a solution?" In his keynote address the master of the rolls, Sir Thomas Bingham, suggested that "there must be a role for the skilled mediator at this early stage." The conference supported this view and explored the use of mediation and arbitration in resolving disputes between doctors and patients and, incidentally, partnership disputes between doctors.

With the review of complaints procedures in the NHS due for publication soon and the universal dissatisfaction with the primacy of litigation in medical disputes, the time is now ripe for the medical and legal professions to put aside vested interests and to combine to produce a workable alternative to litigation.

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1 Forsythe M. Arbitration and the internal market. *BMJ* 1994; 308:151-2. (15 January.)

Screening for breast cancer

EDITOR,—On the basis of their interpretation of the results of the NHS breast screening programme for 1991-2[1] D J Watmough and K Kumar suggest that women aged over 50 should be screened for breast cancer by clinical examination by general practitioners rather than by mammography.[2] Their deductions from the data presented are, however, erroneous. They state that 1465 (22%) of the detected cancers were impalpable and conclude that 78% could have been found by clinical examination. The original paper does not specify the number of palpable cancers. It says that there were 1468 invasive cancers ≤ 10 mm in size, which does not equate to the number of impalpable tumours. Only 39% of the breast cancers that we detect by screening are palpable, even when the woman is examined by an experienced breast surgeon aware of the site of the mammographic abnormality. The Forrest report concluded that clinical examination is not an effective screening method when used alone. We know of no more recent data to contradict this conclusion.

The authors question whether compression of breast cancers during mammography might disseminate malignant cells. There is no evidence that this occurs. If it did the significant reduction in mortality shown in the randomised controlled trials of screening would not have occurred.[3] The authors are also incorrect to suggest that mammography is unnecessary for palpable breast cancer; the treatment options may alter as a result of mammographic findings.

It is now established that mammographic screening performed to high standards can significantly reduce the mortality from breast cancer in women aged over (but not under) 50.[4] The performance figures published by the NHS breast screening programme that we are achieving those standards.[1] This high quality of the breast screening programme has stimulated improved care for women with symptomatic breast disease, particularly the development of multidisciplinary specialist breast clinics, as suggested in Lesley Elliot's personal view.[5] We run such a clinic, seeing women within 48 hours of referral by a general practitioner. Everything necessary for diagnosis is performed in one visit, and results are provided immediately if they are normal or within two further working days if a possible abnormality is detected.

Screening by mammography is the only intervention that has significantly reduced population mortality from breast cancer. We support continued research into all aspects of breast cancer, but the suggestion that this should be funded by the cessation of the national screening programme is misguided and ill informed.

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1 Chamberlain J, Moss SM, Kirkpatrick AE, Michell M, Lyons J. National Health Service breast screening programme results for 1991-2. *BMJ* 1993;307:353-6.
2 Watmough DJ, Kumar K. Screening for breast cancer. *BMJ* 1994;308:202. (15 January.)
3 Roebuck E. X-ray mammography and breast compression. *Lancet* 1992;340:366.
4 Royal College of Radiologists. *Guidelines for those involved in planning mammography in asymptomatic women.* London: RCR, 1994.
5 Elliot L. Breast cancer: a fighting chance. *BMJ* 1994;308:210. (15 January.)

General practitioners' role in commissioning

EDITOR,—Jonathan P Graffy and Juliet Williams are right to conclude that "health authorities must be prepared to share important decisions and offer representation at every level if a commissioning partnership is to be based on trust."[1] In Walsall this representation in the commissioning of services occurs at three levels.

Firstly, service review meetings with local providers take place regularly, at which one or often two general practitioners are part of the purchasing review team. Secondly, at the health authority level a local general practitioner is a non-executive member, able to report the view of his or her colleagues direct to the board. Thirdly, and, we think, innovatively, we have funded six local general practitioners to work on a sessional basis as "general practitioners in public health medicine." These general practitioners, who represent different localities in the borough, liaise with their colleagues to ascertain their views on health needs locally and to receive their impressions on the quality of care at local provider units. In addition, though these general practitioners may not be entirely representative of all local practitioners, they act as a sounding board for the health authority to test innovations or changes in practice and provision of services locally.

Information fed back by these general practitioners at a monthly meeting with the authority's executive officers is minuted and concerns are identified. The authority's proposed action in relation to these problems is then tabled at the next meeting for further discussion. To date, most of the feedback has concerned the acute services (which concurs with Graffy and Williams's comments), although several community unit and public health issues have been addressed. It is hoped that these latter two areas will become an increasing focus of the group's work, thus helping to re-establish links between public health and general practice, which the authors see as "the two branches of the profession . . . [that] . . . may have lost touch."

General practitioners are in a unique position to speak on behalf of their patients' health and health care needs. Like City and Hackney Health Authority, we in Walsall have recognised this and involve general practitioners in the commissioning process at every level.

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1 Graffy JP, Williams J. Purchasing for all: an alternative to fundholding. *BMJ* 1994;308:391-4. (5 February.)

Invasive meningococcal infection after splenectomy

EDITOR,—Various articles have emphasised the lifelong risk of overwhelming sepsis after splenectomy,[1] and the importance of immunising asplenic patients with polyvalent pneumococcal vaccine.[2,3] Mary McMullin and George Johnston point out that, while *Streptococcus pneumoniae* is the most common infecting organism, *Haemophilus influenzae, Neisseria meningitidis,* and *Escherichia*