to psychotherapy, which could result in some of the most disturbed patients failing to get the treatment they need.

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1 Fahy T, Wessely S. Should purchasers pay for psychotherapy? *BMJ* 1993;307;576-7. (4 September.)

Modern witch hunting

EDITOR,—Tony Smith should take more care when hunting the witch hunters.[1] While he is obviously upset at the effect of a dispute over whaling on certain Norwegian communities (a topic on which I cannot comment), many of his other targets are not as guilty as he would wish us to believe.

The campaign against the environmental effects of nuclear power has been largely vindicated by events at Three Mile Island and Chernobyl; it is hard nosed financial considerations that today are deterring power generators in the United States from investing in further nuclear power stations. Concerns about clusters of childhood leukaemia around Sellafield, which once looked as outlandish as more recent concerns about electric power lines, gave rise to research that has thrown new light on both the cause of malignant disease and the dangers posed by exposure to low level radiation.

The Debendox affair, though perhaps a little hasty in its conclusion, was none the less understandable given the memory of thalidomide—another antiemetic claimed by its manufacturer to be safe in pregnancy. Current recommendations to avoid all drugs in pregnancy unless absolutely necessary seem to be sensibly cautious and are in line with the withdrawal of a compound drug that seems to have been prescribed indiscriminately in some communities. The lay campaign against the excessive use of benzodiazepines, to which Smith also refers, was vindicated, and the profession is now much more cautious in their use. The view that excessive carbon dioxide emissions carry appreciable environmental dangers has gained impregnable scientific respectability.

Smith seems to share with the campaigners he denigrates the absolute certainty of his rectitude, and, sadly, this does not seem to be based on objective assessment of any evidence. Perhaps a little uncertainty and compromise are called for.

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1 Smith T. Modern witch hunting. *BMJ* 1993;307:629. (4 September.)

Consultants' league tables

EDITOR,—I am puzzled why consultants in West Midlands region should be so outraged at the publication of waiting times for outpatients and inpatients.[1] In this teaching hospital my outpatient waiting list for non-urgent appointments is nine months, and in the district general hospital where I also work the waiting time is 18 months.

I have the help of only a senior house officer, apart from during one session, when a medical registrar attends just for outpatient work. In 17 years as a consultant I have never taken my full quota of study leave, and I took overseas study leave for the first time this year. The problem has been pointed out to the management at district and regional level, but only now is there some sign of a response. If consultants do not fulfil their sessional commitments and do not start clinics punctually they should feel ashamed and deserve criticism. I suspect, however, that such failings apply to only a minority. I feel sorry for patients who have to wait so long, but if my outpatient waiting times were published I would feel neither angry nor embarrassed.

All that the NHS reforms have succeeded in doing is revealing what the profession has known for so long—namely that the health service cannot meet the expectation of patients and that the patient's charter, though laudable in its aims, cannot be achieved without a considerable expansion in the number of consultants.

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1 Beecham L. Consultants outraged by league tables. *BMJ* 1993;307:699. (18 September.)

New weightings for analysing prescribing in general practice

EDITOR,—Sarah J Roberts and Conrad M Harris's paper on "age, sex, and temporary resident originated prescribing units"[1] is a further attempt to facilitate comparisons of general practitioners' prescribing habits.[2-5] We believe, however, that the objective of deriving a demographic weighting "to replace the existing system of prescribing units used in analysing prescribing by general practitioner in England" has yet to be achieved.

Robert and Harris have based their prescribing unit on information on relative costs. We wish to raise an issue that the authors highlight in their methods section: "Because no detailed data were readily accessible for modelling cost based relative prescribing rates directly, an indirect procedure was adopted." We have published a direct assessment of relative cost based prescribing rates,[2] and our work is continuing with a much larger and geographically spread population. We have calculated data comparable with those of Roberts and Harris from our paper and present here cost based prescribing rates by patients' age and sex and the comparative cost per item rates derived from direct prescribing data (table).

The table shows that Roberts and Harris's cost per item model underestimates the effect of men in the age groups 25-64 and overestimates the effect of men and women in the age group ≥75 compared with our findings. The effect of this on the relative cost based prescribing rates and thus the proposed new prescribing unit is to overestimate the effect of women in the age groups 65-74 and ≥75 and to underestimate the effect of men in the age group ≥75.

We accept that this comparison is problematic because Roberts and Harris's data on items prescribed per person are theoretically more accurate, being based on 90 practices (although the data on the number of patients and geographical spread of the practices are not presented) compared with our two practices in the north east of England with 16 300 patients. They presented insufficient data, however, for us to apply our assessment of direct costs per item to their information on items per person.

The cost per item model used by Roberts and Harris is based on previous work by one of us and colleagues[3]; this was based on prescriptions for one month in two practices with 32 254 patients. This work, although innovative at the time, was hampered by the inaccessibility of paper prescriptions, and the methods used may have resulted in incomplete collection of prescriptions, particularly for elderly people. This is why our later, continuing study came about, with its new computerised method; the collection of prescriptions has been validated as complete.

We believe that the future weighting system should use information on both items and costs independently.[2] We do not think that a replacement for the prescribing unit has yet been developed.

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1 Roberts SJ, Harris CM. Age, sex, and temporary resident originated prescribing units (ASTRO-PUs): new weightings for analysing prescribing of general practices in England. *BMJ* 1993;307:485-8. (21 August.)
2 Purves IN, Edwards C. Comparison of prescribing unit with index including both age and sex in assessing general practice prescribing costs. *BMJ* 1993;306:496-8.
3 Edwards C, Metcalf D, Burr A, Watson K, Steward FCN, Jepson MH, *et al.* Influence of patients age on drug costs: an investigation to validate the prescribing unit. *International Journal of Pharmacy Practice* 1991;1:73-8.
4 Forster DP, Frost CE. Use of regression analysis to explain the variation in prescribing rates and costs between family practitioner committees. *Br J Gen Pract* 1991;41:67-71.
5 Sleator DJD. Towards accurate prescribing analysis in general practice: accounting for the effects of practice demography. *Br J Gen Pract* 1993;43:102-6.

Description of ME in disability handbook

EDITOR,—We were disappointed that Charles Shepherd considered that he was free to make an unauthorised disclosure of part of a draft revision of the *Disability Handbook's* chapter on myalgic encephalomyelitis.[1,2] The Disability Living Allowance Advisory Board sent a provisional draft to the ME Association for comment as part of its normal consultation process before advising the secretary of state on a final text for publication. Shepherd's letter summarises selected parts of the draft's text but, lacking completeness, may have misled readers.

We hope that the final text of the section on myalgic encephalomyelitis will provide a balanced account of current knowledge about, and thinking

Comparative relative cost based prescribing rates and cost per item rates by patients' age and sex

	Age (years)								
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	≥75
Comparative relative cost based prescribing rates									
Roberts and Harris's study[1]:									
Males	1·00	1·02	1·28	1·32	1·89	2·96	5·74	9·54	9·34
Females	0·91	1·00	1·81	2·05	2·78	4·06	6·08	9·38	11·48
Purves and Edwards's study[2]:									
Males	1·00	1·04	0·74	1·50	2·33	3·57	6·49	9·22	10·37
Females	0·72	0·90	1·77	2·29	2·92	4·47	6·07	7·64	7·80
Comparative cost per item rates									
Roberts and Harris's study[1]:									
Males	1·00	1·75	2·85	3·00	3·25	3·25	3·15	3·05	2·70
Females	1·00	1·75	2·15	2·15	2·70	2·75	2·50	2·50	2·25
Purves and Edwards study[2]:									
Males	1·00	2·16	2·29	3·57	4·17	3·71	3·62	2·96	1·28
Females	0·88	1·86	2·19	2·41	2·84	3·17	2·53	2·34	0·90

on, the condition. It will probably conclude that myalgic encephalomyelitis is a separate entity within the group of disorders encompassed by the chronic fatigue syndromes and that some affected people remain disabled, make little or no progress, or even deteriorate over time. The revised chapter will also, however, provide information about the majority of people with myalgic encephalomyelitis, in whom disablement is neither severe nor permanent.

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1 Shepherd C. Description of ME revised in disability handbook. *BMJ* 1993;307:869. (2 October.)
2 Aylward M, Dewis P, Scott TP. *The disability handbook.* London: HMSO, 1992.

Screening boys for growth delay

EDITOR,—Glenn Matfin and colleagues recommend universal screening of boys' genital development in adolescence by school doctors.[1] This may not be productive for several reasons. Firstly, no other screening procedure is performed at this age by doctors. Establishing genital screening would therefore be costly in time and resources. Secondly, the embarrassment of adolescent boys at the idea of being examined by (usually female) school doctors would lead to absenteeism on the day of screening. Thirdly, it is known that children with abnormalities may not attend surveillance programmes —for example, children with sensorineural deafness often miss a health visitor's screening test. Finally, the authors do not assess how many boys would have to be screened for one treatable case to be detected.

The findings of specialist centres do not generally support population screening unless they are accompanied by information on the size of the population from which cases are drawn. Constitutional growth delay is already screened for and detected by the growth surveillance programme carried out by school nurses. Children in whom abnormalities are found should be referred to the school doctor for further assessment. This seems a more acceptable approach than employing doctors to examine boys' genitalia.

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1 Matfin G, Bouloux P, Kirk J, Besser M. Screening boys for growth delay. *BMJ* 1993;307:682. (11 September.)

The end of the GMC?

Government and GMC inquiries are complementary and not in competition

EDITOR,—Richard Smith raises profound issues relating to professional self regulation and the role of the General Medical Council (GMC).[1] However, his basic premise, that the government is "sidelining the GMC and with it the self regulation [of] the profession," is mistaken. I must emphasise that the Health Departments' working group reviewing guidance on doctors' performance and the GMC's proposals for new performance procedures are dealing with aspects of medical performance from entirely different perspectives. They are complementary.

The group that I chair, which is reviewing guidance on doctors' performance, is looking at the existing NHS circulars and other relevant guidance available to the NHS and other employers of doctors for identifying and dealing with doctors whose performance seems to fall below acceptable standards. The group wishes to ascertain how relevant and effective the guidance is in today's NHS and whether it needs to be simplified.

The existing powers of the GMC, however, derive from the Medical Act 1983. They cover only those offences amounting to serious professional misconduct, which can result in erasure from the medical register and the loss of a doctor's livelihood. The council's proposals for new performance procedures are intended to enable it to deal with situations in which a doctor's pattern of professional performance is seriously deficient but does not amount to serious professional misconduct.

These two initiatives are complementary and reflect the different responsibilities of the Department of Health and the GMC in relation to issues connected with doctors' performance. There is no doubt that the government is committed to the continuation of self regulation and to stengthening the statutory arrangements that support the role of the council.

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1 Smith R. The end of the GMC? *BMJ* 1993;307:954. (16 October.)

Government not the GMC failed with implementing performance procedures

EDITOR,—It would be most unfortunate and unfair if Richard Smith's editorial on the General Medical Council (GMC)[1] was to be interpreted as implying that the council has failed to provide leadership in reviewing the performance of medical practitioners: the president has shown considerable personal initiative and commitment with regard to procedures to review doctors' performance. There has been exhaustive consultation with every interested party, both within and outside the profession. The failure of implementation is demonstrably not that of the profession but that of the government, which, despite earnest pleading, has failed to accept the profession's advice about the urgency of legislation.

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1 Smith R. The end of the GMC? *BMJ* 1993;307:954. (16 October.)

GMC losing control

EDITOR,—Self regulation of the medical profession is unusual in the European Community, being limited to the General Medical Council (GMC) in the United Kingdom and the Medical Council in the Republic of Ireland, which itself follows the GMC model. The common market in medicine has been slow to reach these islands, and in the new NHS—where market forces are tearing through organisational practices considered to be protectionist by health care systems strategists[1,2]—the GMC acts as a barrier to the opening up of the medical profession. Whether by design or default, the storming of this barricade has reached an advanced stage, leading to concerns regarding the GMC's responses to recent events.[3]

For tactical errors there have been. The council has failed to acknowledge public complaints regarding its performance while being unable to convince the government of a mechanism for dealing with inadequate performance of some doctors. It has failed comprehensively to address concerns regarding its constitution, thus permitting parliamentary mumblings, on both sides of the house, to develop into direct calls for its suspension. It has failed to accept, let lone anticipate, the need for urgent changes in medical education. And it has failed to recognise the imperative for changes to the medical register that will fully address the needs of the public, national regulatory bodies, and the European Commission while ensuring that control of the profession is retained by the profession.

The last mentioned is the most damaging. For were the GMC to lose control of the register—the recognition of qualification and of specialisation—the potential for NHS trusts to employ whom they wanted, and how, would be greatly facilitated. And the development of specialist clinics, freed from advertising constraints, would undermine the principle of referral by general practitioners, thus completing the agenda of the free marketeers.

"Too little" has been characteristic of the changes undertaken by the GMC. In May next year the profession will have the all too rare opportunity of judging this council and of electing a new one. Judge wisely: it may well be our last opportunity to retain our professional control and identity; there is growing concern that it may already be too late.

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1 Miller J. Competition law and anticompetitive professional behaviour affecting health care. *Modern Law Review* 1992;4: 453-81.
2 Goldstone D. *Opening the medical monopoly.* London: Adam Smith Institute, 1992.
3 Smith R. The end of the GMC? *BMJ* 1993;307:954. (16 October.)

Reducing a dislocation in the nineteenth century

EDITOR,—Derek Fair's personal view, in which he mentions descriptions of the Hippocratic method for reducing a dislocated shoulder,[1] reminded me of an incident told to me by my father many years ago. In the later years of the nineteenth century he was on attachment, as a medical student at Edinburgh University, to a general practitioner near Falkirk.

A message was received on a Sunday morning that the local laird had fallen down after drinking the night before and had injured his shoulder. My father and the doctor attended the patient, and it was obvious that he had dislocated his shoulder. Kocher's method was tried but failed to reduce the dislocation. The doctor then explained to the patient that he would have to try the method with the "unbooted heel," as it was called in those days; he started to remove his shoe, then stopped. Turning to my father, he said, "Perhaps you would like to try?" My father was shaken, not expecting to be asked to carry out this rather violent manoeuvre on so important a private patient. However, he agreed and the shoulder went back quickly.

On the way home he tentatively asked the doctor why he had given him this task. After a slight pause for thought the doctor said, "Well, I'll be honest with you, my boy. I suddenly remembered that I had a large hole in my sock and I couldn't remember which one."

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1 Fair D. Thoughts on Pye. *BMJ* 1993;307:808-9. (25 September.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.