KIDNEY DONORS

All applicants for first provisional driving licences will in future be sent a kidney donor card from the Driver and Vehicle Licensing Centre at Swansea.

DIAMORPHINE

The UK remains the principal user of diamorphine, and the quantity used increased from 41 kilograms in 1971 to 57 kilograms in 1975.

During the last five years there has been little change in the world consumption of cocaine, codeine, dihydrocodeine, ethylmorphine, hydrocodone, methadone, morphine, oxycodone, and pethidine. The use of diphenoxylate, pholcodine, and piritramide is increasing, while thebacon, normethadone, and ketobemidone are being used less than before.

Reference

Statistics on Narcotic Drugs for 1975. United Nations publication E/INCB/35. London: HMSO.

VIOLENCE BY EX-BROADMOOR PATIENTS

One patient in ten released from Broadmoor security hospital between 1960 and 1965 committed some type of violent assault during the next five years, the conference of the British Psychological Society was told at Exeter.

None of the former patients committed murder in that time, although two did so later. Mr Anthony Black, a consultant clinical psychologist at Broadmoor, said:

"These figures go a long way to allaying public fears that patients are being let out too soon," he said. Of 128 patients under review, 62 were homicide cases and 30 others had been involved in violent assaults.

The fact that after release only 13 committed any kind of violent crime in the next five years was encouraging. He added: "Looking at it at its worst, we can say that possibly a fifth had subsequent imprisonment."

More than a third of the patients under review had appeared in court during the five-year period, mainly for minor offences such as shoplifting or drunkenness. About one Broadmoor patient in five had been readmitted to a mental hospital within five years of release, many of them for only days or weeks.

Reference

The Times (1977). 5 April.

NHS

"We are the largest employer in the country. In 1975 we had, for example, over 50,000 more nurses working in the National Health Service than there were in the early 1970s. If our manpower continues to expand at the rate of the last 20 years, by the year 2100 every job in Britain would be in the Health Service, no one would be making goods for us to buy and to sell abroad to pay for our food and essential raw materials."

Reference

Ennals, D. (1977). Speech in London, 28 January.

NHS EXPENDITURE

Mr Moyle, for the Secretary of State for Social Services, replied to a Parliamentary question about the cost of the NHS including health services provided by local authorities up to 1973/74. The amounts were as follows:

	£ million
1971-72	1,981
1972-73	2,257
1973-74	2,560
1974-75	3,346
1975-76	4,564 (estimated)

POPULATION DECLINE

In the 12 months from mid-1974 to mid-1975 the population in England and Wales fell, for the first time recorded in recent times.

Reference

Office of Population Censuses and Surveys (1976). *Population Trends,* No. 6. London: HMSO.

MEDICAL STUDENTS

In the academic year 1975/76 2,802 medical students were admitted to medical schools in England and Wales, and the provisional figure for 1976/77 is 2,957.

DOCTOR-PATIENT RATIOS

The average numbers of registered patients per NHS doctor providing the full range of general medical services on 1 October 1975 in Great Britain were: England—2,300, Wales—2,100, Scotland—1,960.

ATTENDANCE ALLOWANCE

Two hundred and thirty thousand people were in receipt of the Attendance Allowance on 30 June 1976.

CANCER FELLOWSHIPS

The American Cancer Society is offering international cancer fellowships in 1977/78 which can be granted only to people "on the staff of universities, teaching hospitals, research laboratories, or similar institutions". Awards will be made to investigators who are devoting themselves either to experimental or to clinical aspects of cancer research.

Further information can be obtained from: International Union against Cancer, Rue du Conseil-Général, 3, 1205 Geneva, Switzerland.

LETTERS TO THE EDITOR

PRESENTATION OF DATA

Sir,

The paper by Dr Harris and his colleagues (March *Journal,* p. 173-177) should not pass without comment. There are four points that I would raise, but the first two I would not restrict to this paper alone, for too many *Journal* articles suffer the same faults.

The first complaint is that there is insufficient information given in the section headed methods. I know that there is a tendency for authors to keep this part of their paper as short as possible because it is perhaps the least interesting piece of their work, but it is crucial for a proper assessment of the work done.

A single example from Dr Harris's paper will suffice to illustrate my point. One of the alleged aims of the study was to measure psychoneurotic levels against self-medication, but we were given only one question which related to self-treatment without any indication of other methods. Are we to assume that the question cited was the only evidence on which the assessment of self-medication was based? If so, what does it mean? The question in its present form ("do you take, most days, not from the doctor, any pill, tonic, or medicine? Yes

or no") is subject to a whole series of interpretations. Obviously other questions were asked because right at the end of the discussion section it is revealed that some patients were taking laxatives, others analgesics, and so on. But where did this information come from and what is it worth? This is not an idle query on my part because Dr Harris demonstrated no less than 11·7 per cent regular self-medicators, which is an immensely high figure bearing in mind the fact that they are asked if they self-medicate *on most days.*

The second point concerns the presentation of the data. Tables 4, 8, 9 and 10 all quote a chi-squared value which is simply not acceptable. The chi-squared technique is not terribly accurate for small samples and it is contraindicated when any of the cells of the table have less than three in them. Not only do the authors not appear to know this, which is startling given that two of them are academics, but they make the classical error of misinterpreting the useless chi-squared value in Table 8 by saying that "the suggestion of significant deficiency of . . . is interpreted as a chance finding". It is not chance, it is bad statistics. Looking through back numbers of the *Journal,* you may note that the chi-squared test is perhaps the most often abused technique in use. I am constantly surprised that the *Journal* referees should fail to identify such a classical and elementary error.

A third point concerns the way in which the authors interpret the findings. They conclude that "this study does not demonstrate any curative effect" and then go on to discuss the possible reasons why this might be so. But who says there has been no cure? The doctor? The patient? No, it appears to be the questionnaire which is being used to measure levels of psychoneurosis. It is vital that studies which measure success or failure, or any other sort of outcome, by means of a questionnaire should recognize the difference between what an artificial questionnaire says is going on and what actually is happening, especially in such a complicated field as psychosocial disorder. To examine the authors' conclusion in this light it is possible for them to say only that their study did not show any beneficial effect in terms of the questionnaire score. Anything else is beyond the scope of such a small study.

Of course, it is possible that the questionnaire has been well validated and is known to correlate very well indeed with the outcome being evaluated. In this case it might be argued that such a conclusion might be justified. The problem here is that it is virtually impossible to be certain that the conditions in which the questionnaire was validated originally were the same as those holding for the current research. Even with a well validated questionnaire the research worker must use supreme caution in interpreting the results.

This brings me to my fourth and final point. The Middlesex Hospital Questionnaire, the questionnaire used by Dr Harris and his colleagues, cannot yet be called a validated instrument. In a study of its use in 545 men it was suggested that it was not a suitable questionnaire for psychiatric screening. The same study found so many elementary design faults in it which would bias the measurements it made that it concluded that until the questionnaire was completely redesigned and re-evaluated in its corrected form it would be impossible to interpret any measurements produced by its use (Williamson *et al.*, 1976).

There remains so much to be done in the field of general practice that it seems to me to be important that we recognize priorities in our future research efforts. It seems equally essential to ensure that research, when it is carried out, is worthy both of publication and of a readership. The *Journal* can make a stand over these matters which could only be applauded and I hope that this letter will take us in that direction.

JOHN D. WILLIAMSON

Athena
Westville Road
Barnsley.

Reference

Williamson, J. D., Robinson, D. & Rowson, S. C. (1976). *International Journal of Social Psychiatry,* **22/3**, 167-188.

THE INDEPENDENT CONTRACTOR AND THE PRIMARY CARE TEAM

Sir,

The draft evidence submitted by the College to the Royal Commission on the NHS (distributed with the December *Journal*) is notable for its support of two principles governing the provision of primary care within the NHS in Britain today. Item ten asserts: "Primary health care should be provided normally by functionally integrated teams of general practitioners, nurses, health visitors, and where appropriate, social workers, supported by receptionists and secretarial staff." Item 13 states: "General practitioners should remain independent contractors so that patients have an independent medical adviser in a state dominated health service."

As far as I know, no one has drawn attention to the inherent antithesis in maintaining these two positions at the same time. At present some nurses in the primary care teams are employed directly by general practitioners. Others, together with all of the health visitors and midwives in the primary care team, are employed by the area health authority, which both appoints and withdraws them from the team, setting limits to their freedom and range of activity within the team. The general practitioner is the only member of the team with the status of an independent contractor.

For some time it has been apparent that this fundamental difference in status is inimical to the "functional integration" of the team that the College rightly believes to be essential to the development of primary care.

There are two ways in which the antithesis could be resolved. On the one hand, general practitioners could be made salaried servants of the area health authority, so losing their independent status and being brought into line with the nurses, midwives, and health visitors. There are many individuals and organizations who support this view, and some of them are very influential. For example, the Society of Secretaries of Welsh Community Health Councils have submitted evidence in favour of this solution to the Royal Commission on the NHS.

There is, however, an alternative approach, one that has not been put forward before, but which nevertheless has everything to commend it. Why not extend independent contractor status to all nurses, midwives, and health visitors who are members of primary care teams? Why should they not be admitted to group practice partnerships? The group practice and the primary team would then become identical, and the members of the practice team, all partners, would select newcomers to the team themselves. The team would then indeed be "functionally integrated". Nurses, midwives, and health visitors would be encouraged to put down roots and stay within the team as do the general practitioners, instead of remaining birds of passage as they so often are today.

The divided loyalties which so often impose great strains on primary care teams would disappear overnight. All members of the team would be true partners, all holding stakes in the enterprise, though not, of course, drawing equal shares. The team could then develop its programme of care far more efficiently than at present.

In our modern society members of the service industries, such as plumbers, electricians, and builders are often independent contractors. Why not members of the caring professions? All the arguments in favour of an independent contractor status for general practitioners apply equally to other