editorial 'Satisfaction with the NHS' Ann and Brian Keeble (July *Journal*, p.269) continue to refer to general practitioners as 'he'. Thinking people have long since replaced the use of the generic 'he' (there are many perfectly satisfactory alternatives). What an irony to perpetuate this outdated form of sexism in an issue which also so elegantly describes the invaluable contribution of women as full time general practitioners.

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The (women) copy editors of the Journal make every effort to avoid sexist words but this one must have slipped through. Ed.

MRCGP examination

Sir,
I have to disagree with Steven Ford (Letters, September *Journal*, p.392) in his assertion that MRCGP is equivalent to some of the specialist examinations and diplomas that he lists. Each of the latter offers the chance of attaining a certain standard of academic knowledge in the relevant specialty. The MRCGP, however, can best be described as an examination for trainees and young principals. I suspect that most consultant obstetricians would be able to attain the DObstRCOG fairly easily, and yet the figures suggest that experienced principals often find it difficult to pass the MRCGP examination.

Surely the time has come for the College to plan an examination for general practitioners that encompasses their overall expertise and skills and which assesses candidates from a practice based perspective. Rather than comparing specialist examinations we could then have an examination and assessment system which would truly represent general practice and which we could rightly be proud of.

C.I.F. RUSSELL

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Advertising in the *Members' reference book*

Sir,
I have just received my copy of The Royal College of General Practitioners' *Members' reference book 1989*. I must protest at the inclusion in it of an advertisement for 'Spagyrik therapy' (p.365). It is claimed that 'this process automatically produces an analysis of the patient's state of health and the required medication.' This all-encompassing claim is backed by no evidence. One would hope that the College's motto suggested a concern for scientific values. The presence of such advertisements in the handbook leads one to doubt this.

It seems that the lavishness of the handbook has now reached such a degree that advertisements will be accepted from anyone, no matter how fraudulent, as long as they pay. The appearance of such advertisements in a College publication lends them an authority they do not deserve, and brings dishonour to the name of the College.

JOHN JUSTICE

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What do you call a man who doesn't reply to letters?

Sir,
Readers of the *Journal* might be interested to hear of the East Anglian faculty's experiences in asking Mr Kenneth Clarke to attend its annual faculty symposium. I wrote a nice letter to the health secretary on 21 June 1989 inviting him to speak on the white paper and its implications, stressing that the faculty was keen to enter into a constructive dialogue, particularly on the more positive aspects. We had no reply. So a further letter was sent on 25 July 1989 asking for an early reply owing to our planning arrangements. On 8 September 1989 our provost, Dr Ian Redhead wrote again to Mr Clarke, again without reply. By the beginning of October we have still heard absolutely nothing, not even an acknowledgement to our letters.

Our experience may be typical of the way that Mr Clarke is choosing to treat the profession.

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DIGEST

This month • patients' criteria • financial incentives • silent HIV • uninformed consent

Government and patient criteria for good health care

As the date for implementation of the new contract for general practitioners draws closer, debate within the profession rages on. The government sees the new contract as a means of improving standards of care in general practice by taking into account the needs of the consumer.

A study, published in the *British Medical Journal*, set out to determine whether patients' criteria of good health care in general practice were different from those of the government. Ten criteria derived from the government's white paper *Promoting better health* were randomly paired with 10 criteria obtained from a preliminary interview study with patients. A group of patients in a semi-rural practice were then asked to give their preference in each pair. The number of times each criterion was preferred was scored and its comparative importance ranked. The patients gave their most important criteria for good health care as a doctor who listens, a doctor who sorts out problems and usually seeing the same doctor. These were somewhat at odds with the government's proposals, and only three criteria originating from the government's white paper were in the patients' top 10. Older people gave priority to seeing the same doctor and having friendly ancillary

staff, while younger people were more interested in routine health checks.

It would seem that the government's idea of good health care is not in accord with the patients' views and this surely does not augur well for the success of the new contract.

(M.K.)

Source: Smith CH, Armstrong D. Comparison of criteria derived by government and patients for evaluating general practitioner services. *Br Med J* 1989; **299**: 494-496.

Financial incentives and physicians' decisions

THE government's proposed changes to the National Health Service and general practitioners' contracts will undoubtedly alter the mix of financial and non-financial incentives facing general practitioners in the UK. This study, based on a national survey of primary care physicians in health maintenance organizations (HMOs) in the USA provides the first quantitative estimate of how financial incentives influence clinical decisions and the use of resources. The method of paying primary care physicians is a significant determinant of the hospitalization rate which, in turn, has important implications for the total expenditure on medical care of the HMO. Compared with fee for item of service payment, the use of capitation and salary-based payment is associated with 13.1 and 7.5% fewer hospital days per 1000 HMO enrollees per year, respectively. Physicians in for-profit HMOs and group model HMOs (in which the HMO contracts with an independent group practice to provide services) also used the hospital less often compared with not-for-profit and staff-model HMOs (where physicians are employed and controlled directly by the HMO). No direct association was found between placing physicians at financial risk as individuals and the risk of hospitalization. A negative association, however, was detected between individual financial risk and the number of outpatient visits for primary care per enrollee. HMOs were also more likely to break even if they placed physicians at personal financial risk for the cost of outpatient tests.

Despite answering some important questions several issues remain outstanding. This study represents the beginning of what should be a series of rigorous assessments of the complex interplay of financial and non-financial incentives, which may influence the behaviour of 'gate keeping' physicians. Much of the variation in HMO profitability and the use of resources remains unexplained. The impact of incentives on the quality of care and patient welfare is an important area for further research, particularly if more reliance is placed on economic incentives for physicians on both sides of the Atlantic.

(J.F.)

Source: Hillman AL, Pauly MV, Kerstein JJ. How do financial incentives affect physicians' clinical decisions and the financial performance of health maintenance organisations? *N Engl J Med* 1989; **321**: 86-92.

Silent HIV infection

SILENT human immunodeficiency virus (HIV) infection without positive antibodies may be more common and last for longer than previously thought. A study of antibody negative men in Los Angeles who still engaged in unsafe sexual practices showed that 23% had HIV-1 isolated from peripheral macrophages. Of these 31 men four seroconverted during this prospective study over a year. They had the virus detected 11 to 17 months before positive antibody tests. The remaining 27 men who were still antibody negative were followed for 28 months after the virus was discovered inside the cells.

Although the structural proteins and antigens to the virus have been detected in previous studies up to about seven to 14 months before seroconversion, the finding of silent HIV infection is important.

Overt seroconversion probably occurs in most people after a certain threshold of HIV-1 replication in the bloodstream has been reached. An HIV-1 provirus has been discovered which may be hidden in the DNA of cells and may need specific stimuli to activate it. There may be different strains of HIV-1 and seroconversion might only occur with certain strains capable of replication. A high CD8-lymphocyte level in seronegative men who harbour the virus may be a cellular response which prevents outbreak of the virus.

There is good and bad news from this article about silent HIV infection. The bad news is that testing blood samples and transplant organs for antibodies may not detect latent HIV infection. The implications for blood transfusion, transplants, insurance reports and the individual patient are of great concern if this finding is confirmed. The good news is that generalized HIV infection might be held under control by the high levels of CD8 lymphocytes found in those patients who remained antibody negative. The fact that the majority of these men with silent HIV virus did not seroconvert suggest that they were able to suppress the viral replication. This may explain why partners of antibody positive men appear not to become antibody positive themselves despite repeated exposure to the virus. Certainly this finding of apparent control of HIV infection by the body's own lymphocytes is very encouraging.

(J.A.)

Imagawa DT, Lee MH, Walinsky SM, *et al.* Human immunodeficiency virus type 1 infection in homosexual men who remain seronegative for prolonged periods. *N Engl J Med* 1989; **320**: 1458-1462.

How informed is patients' consent?

REQUESTS from insurance companies for medical information about patients are usually accompanied by signed consent from the patient. A recent study has examined how well informed patients really are when they consent to the release of this information. A questionnaire containing six simple questions was sent to 226 patients whose general practitioners had been asked to complete a personal medical attendance report for an insurance company. Among the 195 patients who completed the questionnaire 52% could not remember having given their consent although 74% were aware that their doctor would be approached to release their medical details. There is a great deal of ignorance among patients as to the type of questions asked by insurance companies and most patients objected to questions on sexually transmitted diseases and the risk of developing the acquired immune deficiency syndrome. A surprising 57% of the patients expected their general practitioner to withhold information on items of a sensitive nature and 44% were unaware that the doctor was obliged to answer any detailed questions after consent had been given by the patient.

This study suggests that patients' consent is in fact not informed consent and unless the situation is altered the general practitioner–patient relationship may be in jeopardy.

(M.K.)

Source: Lorge RE. How informed is patients' consent to release of medical information to insurance companies? *Br Med J* 1989; **298**: 1495-1496.

Contributors: Moya Kelly, Glasgow; John Forbes, Edinburgh; Jonathan Anderson, Glasgow.