

hyperpyrexia or suxamethonium apnoea) but generally we do not communicate directly. It might be argued that until now, in most cases, this has not mattered. However, our work pattern is changing and the interface between our specialties is increasing, and we may soon feel the need to be communicating with one another more often.

The interface is most obvious when considering day-case anaesthesia and surgery, and when patients are admitted on the morning of elective surgery but remain in hospital for a few days subsequently. These forms of patient management will increase in the future. There are powerful reasons why this is so. In most cases patients prefer to be at home and in all cases there are considerable financial savings if they are. Improved surgical techniques (such as laparoscopic procedures) and less toxic anaesthetic drugs, will also contribute to the continuation and expansion of these services.

It is estimated that day-case anaesthesia and surgery currently account for about 20% of all operations performed in the United Kingdom. The number of suitable procedures is increasing all the time and recently at the Royal United Hospital, Bath, I was involved in a study to look into the feasibility of day-case laparoscopic cholecystectomy. In the United States of America (where I am temporarily working) nearly 60% of all operations are performed in this manner. Here the main impetus has come from insurance companies, whose main concern is to reduce expenditure. Thyroidectomies, hysterectomies and laparoscopic cholecystectomies are often performed as day cases.

In the UK, admitting patients on the morning of surgery is uncommon but is practised for ear, nose and throat operations, particularly in paediatric patients (such as, for tonsillectomies). At the Bristol Royal Infirmary patients are seen and assessed by an anaesthetist in a pre-admission clinic. In the USA same-day admissions are far more common than in the UK. Unless special pre-operative preparation is indicated (such as before large bowel surgery) patients are seen and assessed in an outpatient clinic by nurse practitioners trained to highlight potential surgical and anaesthetic problems. Blood is taken for required investigations, and other tests (for example, electrocardiograms, chest x-rays and lung function tests) are arranged if necessary. Patients then return home until the day of their admission. Even some patients for coronary artery bypass surgery are admitted from home on the morning of surgery. Thus, in the USA, the visit by the anaesthetist the night before has been dispensed

with. This is a great loss, especially as patients so often remark how much more they fear the anaesthetic than the surgery. Not only can many of the patient's anxieties and fears be laid to rest, but post-operative analgesia can also be discussed, and patients can be instructed on the use of patient-controlled analgesic pumps for post-operative pain relief.

The financial forces now at work in the UK health care system will result, I am sure, in steadily increasing numbers of day-case procedures and same-day admissions. I know that patients already turn to the general practitioners for pre-operative reassurance and advice. They will rely on general practitioners even more in the future. In order to meet this need general practitioners will want accurate and detailed information of the planned procedures. This will only be achieved if there is full and frequent exchange of information between general practitioners and anaesthetists.

I believe that patients in the UK are currently getting a 'better deal' than patients in the USA. Maintaining high standards through the inevitable changes that we face will require an increase in the cooperation and communication between our specialties. I, for one, am looking forward to this.

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Continuing medical education programmes

Sir,
Between 1986 and 1991 the recording of clinical care in the medical records of the diabetic patients in Carney and Helliwell's study improved considerably, but the patients' biochemistry did not (*March Journal*, p.149). Between these dates, the authors had provided an extensive educational programme to the 13 practices in the Tynedale area, and practices had adopted protocols for diabetic care. The participating practices can be congratulated on their improved data but, as the study had no controls, we do not know how much of the change was the result of the programme of postgraduate education and the protocols and how much to other factors.

An effective postgraduate medical education programme is one which produces a better outcome (educational or clinical) among the participants than is found in controls who did not participate in the pro-

gramme. In several settings, however, randomized controlled trials have demonstrated that continuing medical education enhances clinical performance in both intervention and control groups.¹⁻³ In other words, in these studies the clinicians seemed to learn nearly as much by hearing that continuing medical education was taking place as by actually taking part in it.

Conversely, improvements in patient outcome which can be shown to result from continuing medical education are relatively rare:^{4,5} there is a wide gulf between improving the knowledge of the clinician and achieving something worthwhile for the patient. Continuing medical education should be evaluated by randomized controlled trials, but sensitive outcome measures are needed to demonstrate its effects.

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MRCGP examination

Sir,
I am glad that Judy Chen found the examination for membership of the Royal College of General Practitioners a stimulating and worthwhile experience (letter, *March Journal*, p.163). I feel far less happy about her suggestions for its improvement.

If the stated object of the RCGP is 'to encourage, foster and maintain the highest possible standards in general medical practice' then this would not be served by raising the pass mark of the examination. If we are serious about our stated aims, we should be moving towards opening the