believe total withdrawal of the capsule formulation is possible by the end of the year.

We will be passing our results to the Advisory Council on the Misuse of Drugs and support the argument that the continued availability of temazepam tablets and elixir will provide adequate formulations for all patients.

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1 Fox R, Beeching NJ, Morrison C, Ruben S, Garvey T. Misuse of temazepam. *BMJ* 1992;**305**:253. (25 July.)

Predicting mortality from cervical cancer

EDITOR,—Cervical screening may be predictive, but it has never been shown to be protective in the ordinary meaning of the word. It is unfortunate that Gerrit J van Oortmarssen and colleagues use the word "protection" in their paper[1] because, although they define the term "relative protection" as meaning "the ratio of the risks in unscreened and screened women," readers have consciously to resist the implication that the screening process somehow confers protection. It does not, or at least has not been proved to do so.

More alarming still is the authors' statement that the International Agency for Research on Cancer's working group on screening frequencies "assumed that all women participate in screening." Could it really have assumed this? If so could its conclusions be flawed? How soundly based is current practice? There has not yet been a prospective, randomised controlled trial of screening or subsequent interventions. The need is as pressing as ever.[2] Perhaps the authors could tell us what would be required.

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1 Van Oortmarssen GJ, Habbema JDF, van Ballegooijen M. Predicting mortality from cervical cancer after negative smear test results. *BMJ* 1992;**305**:449-51. (22 August.)
2 McCormick J. Cervical smears: a questionable practice. *Lancet* 1989;ii:207-9.

EDITOR,—The report of Gerrit J van Oortmarssen and colleagues[1] shows that the potential effects of screening strategies need to be evaluated carefully. The authors suggest that five yearly screening from age 35 could have a similar impact on mortality from cervical cancer to that of more intensive and potential expensive strategies. This is based on as yet unattainable ideals: that all women enter the screening programme and are screened at the recommended intervals and that the sensitivity of the screening test remains constant across the vast array of potential smear takers.

Although mortality is a major end point for evaluating screening policies, this measure takes no account of the profound consequences to patients of the morbidity, both treatment related and psychological, of a diagnosis of cancer. On these grounds, reducing disease incidence—that is, prevention rather than cure—remains a vital component of screening. The need to address potential negative health effects of additional diagnostic and therapeutic procedures induced by screening is important and clearly needs critical evaluation, but it is premature to suggest that the magnitude of the problem merits allowing a proportion of women to develop invasive malignancy as long as no excess mortality results.

We agree that asymptomatic presentation due to abnormal cytology carries a better prognosis than presentation due to disease related symptoms, almost certainly because asymptomatic disease is more likely to be small volume and early stage. Our observations in stage I disease confirm this impression, with superior disease free survival in those presenting with abnormal cytology than in those presenting with symptoms[2] because of the correlation between symptoms and disease volume. Recent cancer registry data from our region suggest a trend toward presentation with early stage disease. Although this observation may not result from screening activity, detecting early invasion will considerably reduce mortality and treatment related morbidity and is a further cogent argument against reducing the frequency of screening.

With the current screening strategy in the United Kingdom no major reduction in deaths from cervical cancer has occurred. The most important high risk group is non-attenders, and every effort should be made to get uniform coverage of the target population. A move towards less frequent screening, no matter how tempting on economic grounds, should be avoided until the ideal of screening the whole female population has been achieved and until any adverse sequelae of diagnostic and therapeutic procedures induced by screening have been more thoroughly evaluated.

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1 Van Oortmarssen GJ, Habbema JDF, van Ballegooijen M. Predicting mortality from cervical cancer after negative smear test results. *BMJ* 1992;**305**:449-51. (22 August.)
2 Buxton EJ, Saunders N, Blackledge GRP, Kelly K, Redman CWE, Monaghan J, *et al*. The potential for adjuvant therapy in early stage cervical cancer. *Cancer Chem Pharmacol* 1990;**26**: 17-21.

AUTHORS' REPLY,—In our paper we addressed the appropriate interval between successive Papanicolaou smear tests and the way that this problem was dealt with by the International Agency for Research on Cancer (IARC) working group on cervical cancer screening. For this reason we followed the concepts and the terminology in the IARC's paper in which the relative protection against invasive cancer was the principal outcome.[1] But we agree with C M Anderson that we should have avoided using the word "protection."

Both Anderson and C J Buxton and colleagues emphasise the impracticability of realising 100% attendance. The IARC group assumed 100% attendance in order to calculate the impact of regular participation. This is the correct approach when the aim is to inform individual women about the benefits of screening. On a public health level non-participation is important. In our calculations of cost effectiveness we assumed 65% attendance, as observed in the Netherlands. We also analysed non-participation and its association with increased risk of cervical cancer in more detail to assess both the public health consequences and the economic consequences of low coverage.[2] The results of this analysis underscore Buxton and colleagues' remark regarding the need for attaining full coverage in the United Kingdom. It seemed that considerable resources may be used to increase participation; this increased participation would yield a greater reduction in mortality than would using these resources to increase the frequency of screening. Indeed, similar arguments can be used to show the importance of a high quality of the screening test. In other words, frequent screening of women who are eager to participate will not greatly improve the performance of the screening programme and will not solve the problem of low coverage and uneven quality.

With regard to the need for a randomised trial, we think that the empirical evidence of the effectiveness of screening—for example, the studies by the IARC group and by others[3]—precludes a trial in which the control group is not screened at all. On the other hand, frequent screening is also unethical because of the adverse health effects for a considerable proportion of the women screened.[4] Therefore, a trial in which two screening intervals —for example, three years and seven years—are compared would in our opinion be both ethically justifiable and informative for practical decision making.

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1 IARC Working Group on Evaluation of Cervical Cancer Screening Programmes. Screening for squamous cervical cancer: duration of low risk after negative results of cervical cytology and its implication for screening policies. *BMJ* 1986;**293**: 659-64.
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Quality of life of cancer patients

EDITOR,—Maurice L Slevin states that doctors may feel that emotional support of terminally ill patients is more appropriately delegated to nurses, psychologists, or social workers.[1] He fails to mention the supportive role of the general practitioner in caring for the physical, psychological, and emotional problems of such patients and their families, and the importance of this role in enhancing the patient's quality of life.

During a six month period, 65% of dying patients in this practice died either at home or in the local community hospital, looked after by their general practitioner and appropriate members of the primary health care team. A minority of these died suddenly, but most of the others spent their last few weeks at home. The general practitioners have a vital role in assessing and supporting the quality of life of such patients, particularly as they are in the privileged position of having an overview of the patient, the family, and the social circumstances, to which hospital doctors seldom have access.

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1 Slevin ML. Quality of life: philosophical question or clinical reality? *BMJ* 1992;**305**:446-9. (22 August.)

Oesophageal achalasia mistaken for anorexia nervosa

EDITOR,—Discussing diagnostic confusion between anorexia nervosa and achalasia of the oesophagus, K M Pagliero states that because "most patients with dysphagia have a physical obstruction endoscopy should be the first choice [of investigation]"—presumably preceding barium swallow.[1]

Achalasia may indeed be misdiagnosed as anorexia nervosa by the unwary because the regurgitation of food masquerades as self induced vomiting, but it should not be forgotten that the

cardinal symptoms of a pharyngeal pouch also include spontaneous regurgitation, weight loss, and dysphagia.[2]

Barium swallow is the principal means of diagnosing both oesophageal achalasia[3] and pharyngeal pouch. Moreover, there is a very real risk of a traumatic oesophageal perforation as a result of entering an unknown pouch, even with a flexible endoscope. Barium swallow is a simple, non-traumatic, cheap, and safe outpatient investigation suitable for most patients with suspected oesophageal pathology, and traumatic oesophageal perforation due to endoscopy in the absence of a barium swallow would be difficult to defend.

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1 Pagliero KM. Oesophageal achalasia mistaken for anorexia nervosa. *BMJ* 1992;**305**:583. (5 September.)
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Partners in practice

EDITOR,—I was concerned to note the omission of the pharmacist from the spectrum of carers portrayed by Constance Martin, although she seemed to consider every possible lay and professional carer who might come into contact with the patient.[1] I am a pharmacist employed as a lecturer within a university department of general practice and one of my research interests concerns the interface of pharmacists and general practitioners and their shared role in the effective and appropriate use of medicines. Recent government publications have endorsed an extended role for the community pharmacist, which would include among other things greater patient involvement and interdisciplinary collaboration with general practitioners.[2,3]

In the hospital setting the pharmacist plays an important and established part in decisions relating to the pharmaceutical care of patients. There is also a definite and equivalent place for the pharmacist in the primary health care team, and this should be acknowledged by the other professions so that the particular skills of the profession are utilised to the benefit of the rest of the team, and most importantly the patient.

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1 Martin C. Partners in practice: attached, detached, or new recruits? *BMJ* 1992;**305**:348-50. (8 August.)
2 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health.* London: HMSO, 1987. (Cmnd 249.)
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Delays in thrombolysis

EDITOR,—J S Birkhead's review of delays to thrombolysis in patients with suspected myocardial infarction[1] raises some important issues with regard to the effective delivery of modern coronary care.

Firstly, now that the components of delay are reasonably well understood it is time to introduce systematic monitoring of the administration of these drugs. This could most easily be achieved by incorporating delay monitoring into the service specification of contracts for coronary care between purchasing authorities and their provider units. Since only a portion of the total delay is the direct responsibility of the hospital service this would have to be broken down into delay between onset of symptoms and calling for help; delay between calling for help and arriving at hospital; and, finally, "door to needle" time. Each component of delay could then be tackled separately and the results of intervention continuously monitored.

Secondly, Birkhead expresses some concern that wider use of self referral to hospital through the ambulance service may lead to inappropriate calls. This is clearly a concern, but as over half of myocardial infarct victims already have established coronary heart disease[2] this problem could be minimised by concentrating advice on self referral to people known to have heart disease or at high risk in the first instance.

Thirdly, the data presented in the review suggest that only 58% of patients later shown to have myocardial infarction received thrombolysis. The reasons for not giving thrombolytic drugs have been presented in a recent study from Edinburgh.[3] These were non-diagnostic electrocardiogram (46%); over six hours' delay since onset of symptoms (18%); peptic ulcer (5%); and "miscellaneous" (31%). Since thrombolytics have such a dramatic effect on mortality an expansion in coverage as well as a reduction in delay is important. Now that delays in thrombolysis have been analysed perhaps it is time for clarification of a feasible target for thrombolytic coverage in patients with myocardial infarction.

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1 Birkhead JS. Time delays in provision of thrombolytic treatment in six district hospitals. *BMJ* 1992;**305**:445-8.
2 Armstrong A, Duncan B, Oliver MF, Julian DG, Donald KW, Fulton M, *et al.* Natural history of acute coronary attacks. *Br Heart J* 1972;**34**:67-80.
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False positive salivary HIV test

EDITOR,—When asked to do an HIV antibody test for insurance, employment, or other, similar purposes I counsel the patient before sending the blood sample to my local public health laboratory. On receiving the result I give a copy of the report to my client and it is up to him or her to use this information in whatever way he or she chooses. I have always refused to send a specimen to a laboratory if I am not going to be informed of the outcome.

Recently a local general practitioner asked me to see a patient; he had been told that the patient was apparently HIV positive. The man required an HIV test for insurance purposes. After counselling by the general practitioner he was asked to produce a saliva specimen, which was dispatched to a named laboratory in a kit supplied by the insurance company. The patient subsequently received a verbal message to see his general practitioner, who had been informed of his HIV status. The insurance company suggested that the man should be given a blood test to check the result of the salivary test. There was nothing in the man's history to suggest that he had been at risk, and the result of the serological test for HIV antibodies was, as expected, negative.

Several disturbing points arise from this case. Firstly, this man, who was happily married with a family, suffered 48 hours of considerable distress, which in someone less well balanced could have led to attempted or even successful suicide. Secondly, although the insurance company assured the general practitioner that all information relating to the patient's original positive HIV test result would be eliminated from the records, what guarantee has the patient that this in fact has been done? Finally, I understand that the salivary test for HIV was developed as an epidemiological tool and in no way was to be a substitute for the serological test. The apparent false positive result of the salivary test must cast doubt on the quality control procedures of the laboratory that performed that inappropriate test.

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Preparing for a foreign fellow

EDITOR,—Lindsay J Smith and Catherine Marraffa's advice to those preparing for a foreign fellow requires expansion to cater for the position of overseas qualified doctors who are not registered with the General Medical Council before they arrive in Britain.[1] Not all primary medical degrees granted overseas are accepted by the council for registration. Many more degrees are accepted for limited than for full registration, and the range of employment open to doctors holding such degrees is limited accordingly.

The granting of limited registration is in addition subject to several statutory conditions, and scrutinising applications is a complex task that takes time. The council advises all overseas qualified doctors planning to come to Britain to get in touch with the council's overseas registration division at least six months before their intended arrival to obtain advice about their eligibility.

Doctors who are eligible for registration must submit the originals of their degrees and other certificates: the council does not accept any kind of copy, including the notarised copies to which Smith and Marraffa refer.

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1 Smith LJ, Morraffa C. How to prepare for a foreign fellow. *BMJ* 1992;**305**:460-1. (22 August.)

Psychiatrists in the new NHS

EDITOR,—By April 1993 there will be about 6500 fundholding general practitioners. From the same date, general practitioner fundholders will purchase for their patients all community and outpatient mental health services.[1] What will this mean for psychiatry?

To predict how fundholding general practitioners might wield these new powers we need to look at how they use and what they say about mental health services now. General practitioners increasingly refer patients to the growing numbers of community psychiatric nurses, clinical psychologists, and counsellors, and when these options are available the number of referrals to psychiatry services are almost certain to fall.[2]

Are these other professionals as effective as psychiatrists? A recently published randomised trial of care for depressed patients in primary care found counselling (in this case by a social worker) to be significantly more effective clinically, more likely to be endorsed by patients, and as cost effective as treatment by a psychiatrist.[3] Other studies have shown other specialist or paramedical staff to be at least as effective as psychiatrists.[4]

The challenge to psychiatry posed by the growth of other professions is not new. Ten years ago Michael Shepherd warned that "the psychiatrist must now be prepared to define his own function if he is to justify his status."[5] General practitioner fundholding and the internal market, however, are crucial new factors in the equation. If the NHS reforms continue in the intended direction there will be a large transfer of resources and power from