long period show the outcome of intervention in primary care in the two practices and that whole population care through organised case finding and audit may reduce risks for at least some high risk groups.

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1 Hart JT, Thomas C, Gibbons B, Edwards C, Hart M, Jones J, *et al.* Twenty five years of case finding and audit in a socially deprived community. *BMJ* 1991;**302**:1509-13. (22 June.)
2 Alderson MR. *Mortality, morbidity and health statistics.* New York: Stockton Press, 1988:75-6.
3 Ashley JSA, Cole SK, Kilbane MPJ. Health information resources: United Kingdom—health and social factors. In: Holland WW, Detels R, Knox G, eds. *Oxford textbook of public health.* Vol 2. Oxford: Oxford University Press, 1991:37.

Confidentiality in medical audit

SIR,—In their editorial on contracts and confidentiality Drs Vivienne Nathanson and Natalie-Jane Macdonald recommend a simple solution to preserving the confidentiality of sensitive data—that it should be identified only by a code and that only doctors should break the code.[1] We have set up a similar mechanism to preserve confidentiality, in this case of general practitioners doing medical audit in Argyll and Clyde.

One of several apparent obstacles for general practitioners doing audit is the cost of collecting data, and we have addressed this by arranging that the health board reimburses administrative expenses from funds set aside for audit. Inevitably, this means that the general practitioners have to be identified. The management does not need to know which doctors are getting which clinical results, but it does need to know that specific support given, whether educational or financial, is time or money well spent as well as that audit is being done and is improving standards.

As in other health boards and family health services authorities, we are appointing part time audit facilitators, but we have also given them the task of buffering the identifiable data from the health board by holding the key to the code. General practitioners in Argyll and Clyde can therefore be reassured that results of those audits that have received the health board's support will remain confidential to their audit facilitator, whose professionalism makes this a high priority. On the other hand, the health board will obtain what it needs to know in a form that makes the data unidentifiable. Furthermore, the management can be more widely reassured that general practitioners are choosing to audit not just the easy subjects but those that are unpromising—those that most need to be audited.

Data can be made unidentifiable by removing proper names and places, replacing dates by intervals, and collecting isolated data into batches. Ideally, the criterion for showing that data have been made totally unidentifiable should be the "*Panorama* test": no maker of the television programme could re-identify the source of data without help from the source.

We agree with the principle that identifiable data should be confidential within the medical profession and suggest that this should extend to sensitive data about doctors. A designated doctor should have explicit responsibility for rendering such data unidentifiable before they are accessible for other purposes such as those of management, the media, or the government.

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1 Nathanson V, Macdonald N-J. Contracts and confidentiality. *BMJ* 1991;**302**:1291. (1 June.)

Audit in new general practice

SIR,—In his article in the series on the future of general practice Dr Richard Baker shows a disappointing lack of faith in the ability of the new medical audit advisory groups to facilitate audit in general practice so long as they pursue the methods of "traditional audit."[1]

His assertion that traditional audit is likely to create antagonism and resistance to new ideas is unfounded, and the limited success of traditional audit so far may simply be because most practitioners have not yet been doing it for long enough. Furthermore, though indeed few examples of successful audit have been reported, this does not necessarily reflect the level of activity in general practice and, as Hughes and Humphrey observed,[2] may have more to do with the politics of publishing. It is a matter for conjecture, but a medical audit advisory group may be just as likely to create antagonism if it attempts to educate doctors in the methods of "total quality management," which some might consider to be a distinctly off putting concept, jargon ridden and smacking somewhat of the emperor's new clothes.

In any case, there is surely a need for us to learn to walk before we can run, and the fact that traditional audit is only a means to an end and needs to be set in the wider context of practice management usually becomes self evident once attempts are made to introduce change.

In my capacity as audit fellow of the Royal College of General Practitioners in the Northern region I have worked closely with most of the local medical audit advisory groups, including two of the four national pilot schemes, and I am heartened by the facilitative and innovative approach that most have adopted. Building on current activity, they aim at empowering practitioners and acting as a resource rather than at instigating and controlling audit activity. Although the commonest approach has been traditional, the variety of local initiatives reflects a diverse strategy, including multidisciplinary projects, the development questionnaires to assess patients' satisfaction, practice team visiting, and involving lay people in setting standards. If medical audit advisory groups are evolving nationwide in the same way I think that we have every reason to be optimistic about the future direction of audit in general practice.

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1 Baker R. Audit and standards in new general practice. *BMJ* 1991;**303**:32-4. (6 July.)
2 Hughes J, Humphrey C. *Medical audit in general practice—a practical guide to the literature.* London: King's Fund Centre, 1990. (Medical audit series 3.)

Medical academics' concerns over pay

SIR,—Each year we stagger from one crisis to another over parity for clinical academic staff and the dire financial position of the Committee of Vice Chancellors and Principals, so we should have sympathy for Dr J Robert Sneyd's appeal for action by deans, professors, and the royal colleges.[1] But let us not forget the plight of these people and institutions. The Department of Education and Science has refused increased funding for the Science and Engineering Research Council and hence medical education and research, although recently an additional £7 million has been found. Already a major scientific research establishment, the Nuclear Structure Faculty, Daresbury, is to close because of inadequate funding for the sciences, at a time when other major industrial nations are increasing funding and training in science and technology. It is not just medicine that is in this parlous state in the United Kingdom.

With the possibility of a medical school (or schools) closing, which dean or professor is going to be the first to speak out? Never mind his or her place in the waiting list for honours, anyone who rocks the boat may find an even greater lack of departmental funds, so where will the finance for the next conference overseas come from? Expect no help from these quarters.

What then can be done? It will have to be painful to ensure that those determining current policy take note. Doctors working in the NHS must support their clinical academic colleagues and as a body withdraw from undergraduate teaching until parity is restored and the principle enshrined in legislation. Unfortunately, I have no faith in the ability of the profession to stand as one when most are not directly affected.

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1 Sneyd JR. Medical academics' concern over pay. *BMJ* 1991;**303**: 251. (27 July.)

Drug Point

Low back pain associated with penicillamine

Drs B BANNWARTH (Centre for Pharmacovigilance, CHRU Pellegrin, 33076 Bordeaux, France), T SCHAEVERBEKE, and J DEHAIS (Department of Rheumatology, CHRU Pellegrin) write: Low back pain is an uncommon reaction to drugs. In some cases it seems to be a manifestation of hypersensitivity to a drug.[1,2] The following case related to treatment with penicillamine reinforces this impression.

A 65 year old woman with rheumatoid arthritis of seven years' duration and a history of anaemia associated with auranofin was taking indomethacin 75 mg daily, paracetamol as required, and a gradually increasing dose of penicillamine. After five weeks of treatment, when the dose of penicillamine was 600 mg daily, she developed fever (40·3°C), central low back pain, and a rash. All drugs were stopped, and the fever and back pain resolved. The rash persisted for several days. One week after her recovery penicillamine was restarted. Five hours after taking the first 300 mg tablet she again developed a fever (38·4°C) and low back pain. Again both resolved spontaneously within 10 hours. Examination on admission showed typical symmetric polyarthritis without extra-articular features. Her haemoglobin concentration was 114 g/l with an erythrocyte sedimentation rate of 75 mm in the first hour. Her plasma urea and creatinine concentrations were normal, as were her serum transaminase, lactate dehydrogenase, and amylase activities. Results of tests for antinuclear antibody were negative. She did not have proteinuria or haematuria. Radiographs of her lumbar spine did not show any obvious lesion. Indomethacin was restarted without further problems.

To our knowledge, low back pain has never been reported during treatment with penicillamine. Its prompt recurrence after rechallenge and its combination with fever and rash suggest an immunoallergic mechanism.[3] This suggests that central low back pain may originate from the spine as a localised form of arthralgia, a well known allergic symptom.

1 Shah M, Taylor RT. Low back pain associated with streptokinase. *BMJ* 1990;**301**:1219.
2 Dickinson RJ, Rosser A. Low back pain associated with streptokinase. *BMJ* 1991;**302**:111-2. (12 January.)
3 Lyle WH. Penicillamine. *Clinics in the Rheumatic Diseases* 1979;5:569-601.