pan-European norm by the end of the year.

In a telex to the British Department of Health the French Health ministry points out that the draft standard requires either of two tests to check for holes—a completely automated electrolysis test to detect holes or micro holes, or a manual water test to confirm the presence of a hole and its location. France argues that the tests are not alternatives. The entirely manual nature of the water test means that there is no definition of a limit or a force to be applied. The French also argue that the tests for tensile strength required by the proposed standard and the sampling plan do not give as good user protection as does the French standard.

The French health ministry says it will only allow condoms satisfying the French standard to be sold in France and argues that this decision would be a justifiable trade barrier under EC treaty provisions for exemptions from free trade rules on health protection grounds. The EC Commission has mandated CEN to write the European standard, which is mentioned in the EC medical device directive. France's stance is therefore quite serious. The British Standards Insitute has warned that it will jeopardise acceptance of the European standard and has asked the British government to lobby the French to change their policy.

AFNOR has also rejected plans for a European standard for female condoms, this time with widespread support from other European standards bodies. The Commission wanted to mandate a female condom standard to support the medical device directive, but AFNOR says existing knowledge and experience with the female condom mean its efficacy as a contraceptive and in sexually transmissible disease prevention is not proven.

Sara Lewis

Rehabilitation of doctors

Doctors and medical students in New South Wales, Australia, can be forced to undergo drug and alcohol rehabilitation programmes if they are found by the NSW Medical Board to be impaired. These programmes—which include membership of Narcotics Anonymous, regular visits to a psychiatrist, weekly urine screening to check for drugs, restriction on the ability to prescribe addictive drugs, and regular review by the Board—have been established under the recently enacted Medical Practice Act 1992.

One of the most significant changes in the new Act is the registration of medical students. It had been noticed that many of the doctors the Board was seeing with drug, alcohol or mental health problems had shown signs of erratic behaviour as students. Previously, medical students in Australia have not been open to either discipline for misbehaviour or enforced assistance for health problems. So students overly reliant on drugs or alcohol, or who had mental illnesses but refused treatment, or who abused hospital staff or patients, could stay at university as long as they kept passing their exams and avoided criminal charges.

The rationale behind the other changes to the Act is that the Medical Board was previously limited to disciplinary actions alone—reprimand, fine, or deregistration—although it has been unofficially recommending rehabilitation programmes for several years. The new Act gives it the power to enforce psychiatric treatment or a drug and alcohol programme without the doctor losing his or her livelihood.

Under the Act, if either the Medical Board or the NSW Complaints Unit receives a complaint about a doctor's professional behaviour, the Complaints Unit will, after a preliminary investigation, refer the matter to a hearing of the Board's professional standards committee. If a drug, alcohol, or psychiatric problem seems to underlie the misconduct, the committee's hearing is suspended, and management of the case switches from a quasi-judicial to a medical approach.

Mark Ragg

Reaccreditation

"There is a growing feeling within the profession that a laissez-faire attitude to postgraduate education is not now possible." So said a working party report of the Scottish council of the UK Royal College of General Practitioners earlier this year. From the debate at the college in London last week two things were clear: first that some form of reaccreditation and/or recertification is inevitable for this branch of medicine (although a policy will not be in place before June, 1994), and second that the profession must take the lead in defining the structure and content of such a reappraisal system.

But confusion abounds. Is the purpose of the exercise to weed out bad doctors or to raise overall standards? Should a group of practitioners who work together be assessed as a unit or as individuals? Will appraisal be by a cheap and simple system of multiple-choice questionnaires or by expensive peer assessment by practice visits and videotaped consultations?

Doubtless, much attention will be focussed on the members of the Royal College of Obstetricians and Gynaecologists, who are the "fall guys" in the continuing medical education field of UK medicine. Their system, which draws on those of American, Canadian, and Australian colleagues is set to start on Jan 1 next year. At its centre will be a roll or register of trained specialists to be kept in the public domain, in London. The register will list all certified senior specialists. But certification will be time limited, and recertification will require the accrual of 200 continuing medical education points in a 5-year period. Points can be given for activities such as attendance of meetings, postgraduate teaching and completion of distance-learning projects. Since this roll will be in the public domain it will be available to groups such as hospital trusts, defence unions, and patients' organisations. It is these organisations, and not the college, who will determine the consequences of a doctor's name not appearing.

Sarah Ramsay

Business of compliance

Doctors wishing to improve patients' compliance with therapy (see p 909) may soon find themselves being offered help if a report on the subject is heeded by its target readership, marketing personnel in the pharmaceutical industry. The prohibitively priced report drives home the message that pharmaceutical companies have been paying too little attention to the extent to which non-compliance affects their business. The report reminds readers that doctors who do not recognise that the patient has been disregarding instructions may conclude that the compound is ineffective. An increase in dose may produce side-effects, which in turn encourages non-compliance. Moreover, an increase in dose frequency is a marketing disadvantage. Loss of sales also results when patients do not get their prescriptions filled or refilled; according to the report the US pharmaceutical industry is losing about 25% of its potential revenues in this way. As the population ages and as the prevalence of chronic diseases rises, the importance to industry of ensuring that prescriptions are refilled increases, says the report, which sees non-compliance as a marketing problem that is as potentially serious as a price cut or a promotional campaign by a competitor, and hence deserving of strategic marketing intervention. One recommendation is that the industry (tactfully) approach doctors, pharmacists (who lose out on prescriptions that are not filled), and health maintenance organisations (which stand to gain if hospital admissions resulting from non-compliance can be reduced) to cooperate in improving compliance.

Vivien Choo

1 Smith M. Compliance: treatment of optimal sales. 1993. Pp 191. $2250. Medstrategy (Nine the Pines Court, Suite A St Louis, MO 63141). Or Inter Market, 5 Rayners Road, London SW15 2AY.