itemised and not for debate may drive
l support elsewhere in Europe and to
ntries.

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ling whether to be a doctor

agree with M J Kelly's views that sixth udents need expert help in deciding to embark on a career in medicine.[1] For two years I have run a course at a large college with the specific aim of educating e medical students about the life doctors that they can make an informed choice ir future career.

ourse runs for two hours a week over 10 nd includes information about courses, uate specialist training, the nitty gritty of daily work, and interview technique with time for discussion. I include half hour l sessions for students, aimed particularly g them to evaluate whether they really do e a doctor. The students greatly appre- frank discussion and game techniques to get the point across.

students whom I have seen, five subse- lecided to pursue another degree course. all bright, most expecting to get AAA or les at A level, but most have little idea of tors do apart from what they have seen on programmes. They usually want to be , none wanting to be general practitioners, have no idea of the huge range of careers edicine. I encourage them to get work e—for example, in a hospital or old nome—and to talk to their general practi- he college also runs a pre-health course, cludes first aid training.

to engender in students the confidence that they have chosen the right career for reasons and not because of parental and pressure, glamorous fantasies, or lack of on about alternative professions that may them with the same satisfaction. It is t so many of our young doctors become ed and angry and regret their choice of is not, however, surprising in view of the bright students are swept along by a her people's enthusiasm and their own . Medicine is a wonderful, varied, and areer also full of heartache and frustra- our duty to educate our future colleagues alism prevail.

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Seeing for themselves. *BMJ* 1991;303:1598-600.
ecember.)
Demoralised doctors. *BMJ* 1990;300:56-7.

J Kelly has taken an imaginative in helping potential medical students to sight into medical school and medical His comment on the approach of teachers rs advisers in schools is right; in my e they have little idea of the demands of The fault, however, is not just on the e schools, for the medical schools are far neless.

l schools need to exert more authority eas: the selection process for medical needs overhauling, and a firmer line on ut those who are misfits is needed. As the person responsible for the preregistration year in this medical school, I know that consultants are concerned that some graduates have difficulty in completing their year as a house officer. These doctors' undergraduate records often show the signs of impending disaster. The arguments for their continuing the course are as Kelly outlined; when they are challenged to account for their poor performance they give many reasons, but how seriously is their commitment to medicine questioned?

I have doubts about the adequacy of the current system of selection for medical school. A considerable financial investment is made to educate a doctor. Is a 10 minute interview, or none at all, an adequate means of deciding who should benefit from this investment? The procedure needs to be more rigorous and professional. Roberts and Porter called for a change in the selection process.[2] Potential recruits to the armed services and civil service and potential national airline pilots undergo a comprehensive selection process.

Students who find their motivation to pursue a medical career wanting may find it difficult to express their fears. This may be reflected in poor reports. Students must be encouraged to seek advice; a genuine doubt about a future in medicine needs to be handled with understanding. Student counsellors, and interested members of staff, have much to offer. Students should know that such advice is available and easily accessible.

Let us ensure that those we select are of the required standard, intellectually and emotionally.

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High potency factor VIII concentrates

SIR,—I am responding on behalf of the United Kingdom Haemophilia Centre Directors' Organisation to John D Cash's article on high potency factor VIII concentrates.[1] The article has been quoted by several purchasing authorities as evidence for lack of benefit from high purity factor VIII. Such a view is an oversimplification. Presently, most factor VIII used in the United Kingdom is of intermediate purity and is prepared, mainly by NHS fractionation laboratories, from voluntary donors. It has been in use since 1985 and found to be efficacious and safe from viral infection. Thus, continuing its use while newer products are being introduced and evaluated seems reasonable.

High purity factor VIII, free from extraneous protein, is both appropriate and desirable. Nevertheless, it should be introduced gradually and, as with any new therapeutic substance, monitored for safety and efficacy.

In 1990 the United Kingdom Haemophilia Centre Directors' Organisation issued recommendations for the treatment of haemophilia and identified certain groups that might benefit from high purity factor VIII. Firstly, patients receiving intermediate purity products who develop an allergic reaction should be changed to a high purity product; this is consistent with Cash's view.[1] Others include patients undergoing major surgery or receiving treatment for the first time. A high purity product provides the haemostatic dose in a smaller volume and is of particular benefit to patients with poor venous access and children. Most patients treated for the first time are children. We accept, however, that any new treatment should be of proved safety in adults before being given to children. Therefore, a paediatric haemophilia working party has been established to address this issue and to plan prospective trials. These trials will also incorporate regimens for planned prophylaxis and an appraisal of the incidence of factor VIII antibodies. Concern has been expressed that treatment with monoclonally derived high purity products is associated with an increased incidence of inhibitors.[2-4]

There remains the question whether high purity factor VIII prevents down regulation of the immune system. Evidence of benefit continues to accumulate, as indicated recently by de Biasi *et al*.[5] Evans *et al* have shown preservation of the immune system in patients treated with only one product of intermediate purity.[6] If a sustained defect in the immune system is evident, however, it seems reasonable to change to treatment with a high purity product, again with careful clinical and laboratory evaluation.

At present Scotland and Northern Ireland are introducing an alternative high purity product for all patients. The product will be fractionated according to the technology of Burnouf *et al*.[7] It will be administered within prospective clinical trials. Thus the place of high purity factor VIII is emerging and, provided it proves to be satisfactory on scientific evaluation, it will attain its rightful place in the treatment of haemophilia within a short time.

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Impact resistance of drinking glasses

SIR,—J P Shepherd and colleagues' letter on the impact resistance of drinking glasses has received considerable publicity in the national press.[1] Ravenhead does not question the accuracy of the experiments, but the conclusions reached are not based on fact.

We do not agree that the drinking glasses used in attacks are usually intact, nor have we found police records to support this statement. If this is the case we find it difficult to understand how lacerations occur. We believe that glass used in "glassing" attacks, whether drinking glasses or bottles are used, is first broken to produce lethal dagger-like spikes. We agree that tempered glassware, if properly tempered, can be stronger than stress free, normal glassware, but this is only in its new, unused condition. Within hours of first being used in a busy pub the strength of tempered glassware deteriorates rapidly and it can become unstable. This is due to surface abrasion, which occurs when it comes into contact with other objects—for example, other glasses and cutlery.

We have yet to find a tempered glass that

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