role of patients in determining their own care. By concentrating on the relationship between professional 'providers' and lay 'consumers' Professor Campbell ignores the positive aspects of enabling people to make choices about their health. In doing so, patients are in a better position to ensure that the services they receive reflect their needs more closely.

The perspective of consumerism has recently been forcibly introduced into a whole range of public sector services. In the NHS the theme of consumerism was introduced around 1983 when Roy Griffiths produced his first report, The enquiry into NHS management, and was sustained and built upon in subsequent green and white papers, notably the consultative document Primary health care: an agenda for discussion, the white paper Promoting better health, and the NHS review Working for patients. All these papers assert that proposed changes are intended to make services more responsive to the consumer and for the consumer to be given wider choice. Given that wider choice, it seems highly improbable that the average patient would wish to be considered as a consumer in matters of health care. In effect, 'consumer' is an accommodating term, imposed on the patient, in order to introduce into the NHS a form of competition, and a market oriented philosophy.

One could argue that the patient is not merely a consumer and, indeed, could more appropriately be described as a partner — a provider of information and case histories, a presenter of illness and disease, a contributor in helping the professional reach a decision, a person actively participating in his or her own health care. Conversely when the new legislation is implemented the real consumers will be those placing contracts with and purchasing services from the hospitals; that is, district health authorities and budget holding practices. The six characteristics of a market relationship summarized by the philosopher Robin Downie, and quoted by Professor Campbell, apply more appropriately to this alternative interpretation, whereby the trading partners are the budget holding general practitioners and the district health authorities on the one hand, and the hospital suppliers on the other.

Despite the repeated assertions that services are to be made more responsive to the patient and that the patient is to be given wider choice, it is difficult at this stage of untested theories and excluded pilot studies to appreciate where these choices lie. Patients will be able to change their doctor and move from one practice to another, but as practices grow larger, even that choice will become limited. It is far from likely that patients will be invited to participate in drawing up contracts which could incorporate specified patient choices and known preferences. Instead patients will be offered the medical treatment they seek where the purchasers have chosen to place their contracts and there is no reason to assume that this will be the patients' choice. This cannot be regarded as a genuine market situation from the patients' point of view. A trading partner would never accept such restricted terms.

It cannot be denied that the market approach implicit in consumerism does potentially enhance the position of the patient, albeit the more confident and articulate patient, but this enhancement can also be found within a participative relationship, where professionals share their decisions with their patients.

Just as there are confident and articulate patients so there are vulnerable patients, some so frightened, confused and emotionally distressed that choices and decisions have to be made on their behalf. It is vitally necessary that protection should be guaranteed to these vulnerable patients. A bill of rights, or patients' charter, such as that already produced by the Association of Community Health Councils in England and Wales, has much to recommend it, not least, as Veatch suggests because it introduces a social dimension so sadly missing in individualized contracts and covenants. In any 'just' society there must be an element of social responsibility for ensuring an equitable sharing of medical provision. In this era of 'cash limiting' there has to be a notion of fair shares; the Patients' Liaison Group is of the opinion that the major flaw associated with consumerism in health care is the ideology of focusing on the individual rather than accepting corporate responsibility for the community.

The unique relationship of trust and understanding between doctor and patient which has evolved over the years will suffer immeasurably if it is seen only in commercial terms. It is being assumed that all patients can converse on equal terms with the doctor; that patients can compete with one another for services; and that patients accept and recognize the full implications of a trading relationship. This is far from the truth. Health care is qualitatively different and should be recognized as such.

Doreen Bugler
Patients' Liaison Group
The Royal College of General Practitioners
14 Princes Gate, London SW7 1PU

References

Prevalence of iron deficiency anaemia
Sir,
Dr Grant's community based study (March Journal, p.112) found 17% of preschool children to have iron deficiency (ferritin level <10 μg l⁻¹) and 3% to be anaemic (haemoglobin level <10.5 g dl⁻¹). In a community based study in Sligo, north-west Ireland, Armstrong found similar results — 40% of the adolescents tested had iron deficiency (ferritin level <10 μg l⁻¹) while anaemia was found in 13% of males (haemoglobin level <13.0 g dl⁻¹) and 7% of females (haemoglobin level <12.0 g dl⁻¹). These two studies suggest that iron deficiency is more prevalent than might be expected.

Dr Grant's suggestion of taking blood samples from all pre-school children when they present for the measles, mumps and rubella vaccine may not be practical but perhaps a more sympathetic ear to the request for a 'tonic' or iron supplement would be appropriate.

HELENA MURRAY
General Practice Training Unit
Sligo General Hospital
Sligo, Ireland

Reference

Diabetic care in general practice
Sir,
I was interested to read the paper by Farmer and Coulter on diabetic care (February Journal, p.56). This was a stimulating paper and the hypothesis discussed, that organized general practice care reduces the rate of hospital admissions, is important.

However, if the admission rates generated in the paper are applied to the 'average practice' with 7500 patients, then this suggests a difference between 'good' and 'bad' practices of less than one admission a year in total to distinguish their varying standards of diabetic care. This does not appear to be a very sensitive discriminator and it would have been reassuring to see the original total chisquared value and the deviation to help assess the clinical significance of the trend result.

I would endorse many of their com-
ments about the organization of care within practices and agree that evaluating care 'needs to be carried out using hard outcome measures'.

C J PACKHAM

11b Church Street
Eastwood, Nottingham NG16 3BS

Reference

Introduction to psychosexual medicine

Sir,
I read with much interest the replies (March Journal, p.126) to my review of *Introduction to psychosexual medicine: for doctors, nurses, students, and other health professionals* (January Journal, p.45).

I am reminded that, despite the full title, the book is 'written by doctors primarily for doctors'. My criticism of the book has led to me being labelled a 'red under the bed'. Nothing could be further from the truth, but such comments do tell us a lot about the value systems of some members of the Institute of Psychosexual Medicine.

Since 1976 I have worked alongside doctors in both hospital and primary care settings, first as a qualified nurse, and then as a psychologist. For the past three years I have been witness to the very busy and often hectic lives of general practitioners. I have always admired the way these professionals share their medicine with both their colleagues in other health professions and with their patients. I would do them all a disservice to recommend a book that does not easily relate to the practicalities of their every day practice life. If this results in being identified as an academic Luddite then so be it.

PAUL MCDONALD
Department of General Practice
Queen's Medical Centre
Nottingham NG7 2UH

Voluntary euthanasia

Sir,
I read the discussion paper by Dr Bliss on euthanasia (March Journal, p.117) with interest, particularly since reference was made to the Hippocratic oath. The relevant part of the oath, which was not quoted, is 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.' The author wants the rights of children to make decisions for their parents who are incapacitated by age or dementia to be recognized. However, rights can only be recognized and exercised provided the rights of others are not transgressed. Quite simply, the right I have to swing my arm ends where another person's nose begins. To make children the arbiters of life and death for their parents is untenable in a civilized society, particularly one which outlaws the death penalty for criminals. The doctor is not there to act as an executioner at the behest of the younger members of a family.

Let us maintain the Hippocratic tradition.

J H SCOTSON
119 Park Road
Timperley, Cheshire WA15 6QO

DIGEST

This month • diagnostic testing • febrile convulsions • arthritis • breast cancer • smoking

Routine diagnostic testing

T HIS article looks at whether routine diagnostic testing is beneficial to the practice of medicine. Although the comments are mainly levelled at junior hospital doctors the underlying message is applicable to medical practitioners in all fields.

There has been convincing evidence over the years that many common diagnostic tests are a waste of time and money and yet despite this the number of requests for these investigations continues to increase. It is often the junior hospital doctors who are the culprits although most senior medical staff cannot escape criticism. The article explores the reason for doing so many tests, such as fear of missing a diagnosis, reassurance for the clinician and for the patient as a result of the increase in prevention and screening and also an increasing fear of medical litigation. It is interesting to note that research among medical outpatients has shown that routine haematological and urine tests contributed to less than 1% of diagnoses while 73% of diagnoses were made on basic history and physical examination alone.

It is suggested that investigative departments should screen requests more rigorously and lay down guidelines for the junior staff. In addition, medical students should be taught more about health economics and cost-effective decision-making in their undergraduate career. In the light of the government's strive for cost efficiency and the introduction of practice and hospital budgets, the use of diagnostic tests may well be an area that general practitioners and vocational trainees will have to reassess. (M K)


Phenobarbitone in the prevention of recurrent febrile convulsions

T HE position of phenobarbitone as a useful drug in the prevention of recurrent febrile convulsions has recently been questioned by clinical studies which report behavioural and cognitive side effects as well as experimental work which has shown deleterious effects on developing neurons. Workers in Seattle have carried out a randomized controlled trial on 217 patients aged between eight and 36 months who satisfied the criteria of the National Institutes for Health for consideration of prophylaxis — very young, more than one febrile seizure, family history of epilepsy, lengthy focal or multifocal seizures (*Pediatrics* 1986; 66: 1009).

Study subjects received riboflavin as placebo or 4–5 mg kg⁻¹ of phenobarbitone per day with riboflavin for two years. The end points were recurrence of seizures and scores on the Bayley scales of infant development and Stanford-Binet scales of intelligence adjusted for age and level of function.

After two years the mean IQ was 8.4 points lower in the phenobarbitone group than in the control group (95% confidence interval, −13.3 to −3.5, *P = 0.0057*). Six months after medication had been gradually reduced and then discontinued the mean IQ remained 5.2 points lower (95% confidence interval, −10.5 to 0.04, *P = 0.052*). The proportion of children remaining free of subsequent seizures did not differ between the treatment groups.

The authors conclude that phenobarbitone depresses cognitive performance in children treated for febrile seizures and that this disadvantage, which persists for several months after drug treatment, is not offset by the benefit of significant seizure prevention. They suggest that as other agents have not proven effective further studies are needed to evaluate newer...