

## THE DEVIL AND THE DEEP BLUE SEA

THE investment of money, material and manpower which our society makes in medical care is vast. But what is being bought? Is it health, and if so how is it defined? The philosopher Ivan Illich tells us that health is simply an expression of our culture. It is not, he says, what the medical profession have made of it: a commodity which doctors supply to consumers who clamour for their goods. If we subscribe to the view of health as a commodity, how is society to cope with the escalating cost? If health is a form of wealth, how are we to decide how much is enough? And who will judge the quality of our goods?

There can be no gainsaying that the care which the profession provides is an expression of our culture. In an age when the media create a global village of the world, each new clinical manipulation (the cardiac pacemaker or the finger-joint prosthesis) becomes immediately incorporated into the expectations of all individuals. Szasz and others have pointed to the growing imperialism of medical care. In psychiatry, particularly, human experience or social deviance is redefined as illness: teaching becomes treatment and the outcome becomes a potential measurement of medicine's utility.

Because the general practitioner stands on the boundary between the patient's expectation and the finite resources of medical care (Marinker, 1973), he is constantly challenged to think afresh about professional goals. This is what we mean when we talk about audit, though for the most part we use the word to refer to measurements of what we do, rather than to a statement about the goals of our frenetic and expensive activities.

The traditional way of defining good quality in medical care has been to follow the dictate of a charismatic leader. Each of us carries the burden of a number of fatuous *obiter dicta* from our early medical education. Now, and particularly in general practice, we are seeking to escape from the inhibitions to progress which are part of this kind of clinical ancestor-worship. In its place we seek to adopt the consensus of the group, and to agree that what men have in common is virtuous. The analysis of prescribing, which the Department of Health and Social Security makes available to the general practitioner, provides an example of the implicit assumptions contained in the politics of consensus. The prescribing performance of the individual doctor is compared with the performance of the local and the national groups of general practitioners. These latter performances (in this case not even a consensus view but a mathematical mean) become the reference of acceptable behaviour. To be deviant is, *a priori*, to be without virtue.

In his excellent study of the relationship between the clinical picture, the diagnostic label and the choice of medication, Howie (1973) examined the clinical performance of doctors in teaching practices in the North-east of Scotland. He suggested that when a majority of doctors respond to a particular clinical problem with a particular treatment, this response constitutes an acceptable standard of clinical work.

Peer group review has gained a new respectability, although it is only charismatic leadership decked out in a thin disguise. For example, was Howie's group of Scottish doctors representative of all general practitioners in the region or in the country? Or

were they an unrepresentative élite, a deviant group of teaching practices, chosen by a charismatic leader?

If we are to make choices about the kind of medical care which we give to people, then the choices must be based on more than the advocacy of an élite—person or group. General practice is faced with the need to make judgments. These judgments link with professional goals expressed in terms of the health of people, and not with measurements of the quality and quantity of the work which doctors put into the system of care.

If Illich is right, and health is culture, not commodity, then the group who must make these judgments is neither good doctors nor all doctors, but all of us who go to make up our society. It is only if we believe that doctors alone are competent to define health and unhealth, that we will be caught for ever between the devil of charisma and the deep blue sea of consensus.

#### REFERENCES

- Howie, J. G. R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 895–904.  
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## SUPPRESSION OF RH-SENSITISATION BY THE USE OF ANTI-D IMMUNOGLOBULIN

**A**T a recent talk, the Director of the North-east Thames Regional Blood Transfusion Service highlighted the vital importance of giving anti-D immunoglobulin to all Rh negative women after abortion as well as to those giving birth to first and subsequent Rh positive children.

There have been many advances in medicine in the last 25 years, but none of more significance than the use of anti-D immunoglobulin for the prevention of iso-immunisation of Rh-negative women during pregnancy.

By the beginning of 1966, evidence was growing that Rh sensitisation given after pregnancy in a proportion of D-negative women could probably be prevented by giving the mother an injection of anti-D serum immediately after delivery. It was realised that the effect of the treatment could not be properly assessed until the outcome of a second pregnancy with a D-positive infant was known (Clarke, 1969).

The Medical Research Council set up a working party and their first controlled trial started in 1966. This confirmed the original hypothesis. Supplies of anti-D serum remained scarce and the large scale trial started in 1967 was planned to determine the lowest effective dose 200  $\mu\text{g}$ , 100  $\mu\text{g}$ , 50  $\mu\text{g}$ , and 20  $\mu\text{g}$  were used. The sera of all treated women were tested for anti-D six months after delivery of the first infant and as many as possible of the treated women were followed up to discover the outcome of their next pregnancy with a D-positive infant.

The details of this trial have now been published (Medical Research Council, 1974). In 800 women followed to the end of a second pregnancy with a D-positive infant the total failure rate was 1.7 per cent which was one tenth of that to be expected in an untreated series. The optimum dose was considered to be 100  $\mu\text{g}$ .

Another trial using 1,000  $\mu\text{g}$ , showed a similar result. (Combined Study, 1971). Of 86 mothers treated, two had antibodies after a second Rh positive infant compared with 20 out of 65 controls. Woodrow *et al* (1971) reported 89 per cent protection rate at the end of the subsequent pregnancy using 200  $\mu\text{g}$ .