LETTERS TO THE EDITOR

MEDICAL ETHICS

Sir,

I was interested to read the article by Drs Jones and Richards (March *Journal,* p. 137) and I wish to draw your attention to a matter in which issues of confidentiality and the protection of the individual are directly involved in relationship to computers.

I refer to the Notification of Birth (National Standard Computer System). This form, which is being adopted for national use but which has not yet been adopted by all areas, has the child's name, address, sex, time and date of birth, and also contains the mother's name, address, date of birth, and a statement of her previous live births, still births, abortions, and miscarriages. It thus contains potentially sensitive information without consent having been obtained from the patient and without the customary "confidential" notice on the form. Furthermore it does not identify the known groups at risk of genetic disease (for example Tay-Sach's disease—Ashkenazi Jews).

It appears that this form with its potentially delicate information might be suitable for coding, as is the Attitudes to Pregnancy Survey which the College is conducting. I hope to draw the attention of my colleagues to the potential erosion of individual liberty in which we may all unwittingly be involved.

M. A. M. B. CARMI

White Lodge
Silver Street
Enfield EN1 3EW.

DISPENSARIES

Sir,

I am working on the history of outpatients and dispensaries and wondered if any of your readers would be able to help me as far as dispensaries outside London are concerned.

Apart from the short-lived Royal College of Physicians' dispensary (1696-1725), the dispensary movement really started with the Aldersgate dispensary in 1770, reached its peak in the late nineteenth and early twentieth century, lost a lot of impetus with the introduction of National Health Insurance in 1911, and finally died with the introduction of the NHS.

Apart from the Poor Law dispensaries, they were of two kinds. First there were the free dispensaries, supported by voluntary contributions like the voluntary hospitals (all the early ones were of this kind), and secondly there were the provident dispensaries, sometimes known as self-supporting dispensaries. The provident dispensaries, the first of which was founded in 1823, were institutions at which the poor above the pauper class made a regular weekly contribution and were able to receive medical care at the dispensary or at home if they were too ill to venture out of the house. The medical officers at these dispensaries were apothecaries in the period up to about 1850 and were then general practitioners, but in many dispensaries, particularly in London, honorary physicians and surgeons also attended at the dispensaries on one or two days a week.

Information about dispensaries in London is fairly easy to obtain, but there has been, as far as I can ascertain, relatively little published on dispensaries elsewhere, especially in the smaller towns. Rentoul (1887) lists 88 provident dispensaries in England, 30 of them in London, and Burdett (1893) in a table of the hospitals and dispensaries in the 34 largest towns in Great Britain and Ireland lists 45 free and provident dispensaries outside London, and 57 in London. Other sources of the same period give similar figures, but it seems almost certain that all these estimates are too low, probably by a large amount.

The dispensary movement served a large part of the population for more than 150 years and played an important role in the development of clinical care in this country. They were a source of income for some general practitioners, sometimes on a reasonable scale, though more often not, I suspect, and they were sometimes a source of strife within the profession, even although they probably worked smoothly most of the time. As such they form a fascinating and hitherto neglected part of the history of medicine, and particularly of general practice.

I should therefore be grateful for any information on provincial dispensaries —when they were founded, when they were closed down, how many patients attended each year or were registered at provident dispensaries, who staffed them as medical officers and how much they were paid, whether consultants held honorary appointments, and any other facts. On a number of occasions dispensaries that were originally free subsequently became provident, and occasionally a free and a provident system were run simultaneously in the same building (interestingly, this was said to be a recipe for disaster: I can imagine why) and I would be interested to hear of such examples. If there are records available, such as annual reports, I would hope to be able to travel to see them sooner or later, or, if they could be sent to me, I would happily refund postage, treat them with the greatest reverence, and undertake to return them safe and sound.

I. S. LOUDON

The Mill House
Wantage
Oxfordshire OX12 9EH.

References

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EPIDIDYMO-ORCHITIS

Sir,

I was concerned by the letter from Dr Graham (March *Journal,* p. 185). Dr Barnes and colleagues (1974) classified epididymo-orchitis as gonorrhoeal, non-specific, or tuberculous, overlooking the fact that the majority of such cases are secondary to urinary infection (Blandy, 1976); but this classification does serve to dramatize the fact that such patients should always be regarded in the first instance as potentially having venereal disease.

Epididymitis complicates two per cent of cases of non-specific urethritis (King, 1972), and in a series of cases in which gonorrhoea was considered possible ten per cent proved to be gonococcal in origin (Furness, 1974).

Pelouze (1944) quoting Benzda's earlier study in German soldiers, described 53·4 per cent of cases of unilateral epididymitis, and 41·7 per cent of bilateral cases, resulting in sterility.

Epididymo-orchitis of venereal origin is not common, but is amenable to specific therapy. The blind exhibition of combined steroids and antibiotics can only be condemned as a bad example of treatment before diagnosis. Such cases should always be referred in the first instance to a venereology clinic. Such clinics offer the possibility of defining the aetiology and exclude other associ-