number of patients on a doctor's list the more attention they get.

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Reference

Lockstone, D. R. (1976) Night calls in a group practice. *Journal of the Royal College of General Practitioners,* **26**, 68-71.

TRANQUILLIZERS AND ROAD ACCIDENTS

Sir,

Having read and heard a great deal of evidence on the association of tranquillizers and road accidents (September *Journal,* p. 533), I have looked in vain for any reference to the conditions requiring the tranquillizers.

My own casual observations of drivers makes me believe that tension and anxiety may often be the cause. Inappropriate, rather than slow, reaction may well be the more dangerous of the two.

I am not referring to the increasing numbers who can no longer face life except through a benzodiazepine haze—only to those who are going through a time of considerable anxiety.

It is easy enough to gather statistics about the percentage of tranquillized drivers involved in accidents but very difficult to find out their degree of anxiety at the time.

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HAY FEVER

Sir,

I read with some interest the prize-winning essay on hay fever by Dr Harland (May *Journal,* p. 265) and was somewhat surprised to read Dr Fields' letter (August *Journal,* p. 498). May I take issue with Dr Fields on a few points?

1. The author of the essay did *not* state that cell-mediated immunity is mediated by IgE; he indicated that, because IgE binds firmly to mast cells, an allergic reaction may be referred to as a 'cell-mediated' immune response. While not accepted under current immunological dogma, such a statement is semantically correct. If Dr Fields wishes to criticize the essay, would he not be better to refer to the statement on p. 266 "that these cells (T-cells) are responsible for the production of IgE immunity" which although not incorrect, gives the misleading impression that T-cells differentiate into antibody-forming cells.
2. I wonder how many general practitioners would be willing to undertake the long and tedious process of skin testing and desensitization described in the essay? Dr Harland discusses these points quite adequately. Further, he stresses that he depended on a specially trained nurse to carry out appropriate skin tests. Without such help, which is freely acknowledged, it is unlikely that this essay would ever have been written.
3. I am somewhat worried by Dr Fields' reference to "delayed hyposensitivity"; I can only assume that this was a misprint since such a condition is unknown to practising immunologists. His use of the term "blocking antibodies" betrays a lack of understanding of serological terminology; in any case, such antibodies are not of the IgE class.
4. I am distressed that you should have allowed publication of the last paragraph of Dr Fields' letter which is little more than a poorly veiled attack on the integrity of the prize-winning essayist and a reflection upon those who judged the essay. Dr Harland states (p. 280): "as I continue to research the literature"—where would any medical research worker start but with the *Index Medicus?* Are we to think that Dr Fields believes that the author wrote his essay on the foundation of *titles* derived from the *Index Medicus* rather than assiduous reading of literature derived from them, and extensive clinical observation?

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EPIDEMIC POLYARTHRITIS

Sir,

Puzzling polyarthritis in patients who have visited Fiji this year may well be due to epidemic polyarthritis. This is a mosquito-borne group A arbovirus disease caused by the Ross River virus, well known in Australia, recorded from New Guinea, and reported as a massive outbreak in Fiji for the first time in the WHO *Weekly Epidemiological Record* (1979).

The risk to visitors, at least during the month of April, is demonstrated by the evidence of a party of 21 people from Wanganui who were in Fiji from 11 to 24 April 1979. Ten had typical symptoms; nine out of 16 who submitted blood samples had antibodies to the virus, although two of these remained symptom free. Other viruses may also be about, as one patient with typical symptoms had three negative tests both for Ross River virus and dengue antibodies.

Clinically, the patient is likely to present with joint swelling, which may soon resolve, whereas moderate pain and stiffness may persist or recur, especially if salicylates are stopped. Generalized macular or maculopapular rash is common around the onset (which is usually accompanied by only mild, if any, pyrexia), but disappears in about a week. In a Wanganui case, a localized papular rash near an affected joint developed months after onset. Typically involved have been the ankle, knee, and interphalangeal or metatarso-phalangeal joints. Major disability has not been reported to me—anxiety about rheumatoid disease seems more important. However, a colleague with experience of the condition in Australia stated that nurses with the disease could be intermittently unfit for duty up to a year from onset.

"Have you been to Fiji or Australia this year?" is now, I suggest, a pertinent question for polyarthritis victims in many parts of the world. Serological identification was carried out by Professor J. A. R. Miles and his colleagues of the Virus Research Institute, University of Otago, Dunedin, to whom I am most grateful.

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Reference

WHO *Weekly Epidemiological Record* (1979). **54**, 191.

NEGATIVE EVIDENCE IN MEDICAL PRACTICE

Sir,

Influenza is one of the most common diagnoses made in general practice, yet how is it made? Largely on the history and the absence of physical signs of any other disease. Virology is rarely carried out on the grounds of time, expense, and the seriousness of the patient's condition. In scientific terms the diagnosis of influenza is not worth much. I once went to a lecture on conjunctivitis given by an ophthalmic surgeon who stated that the majority of cases were bilateral. Most general practitioners will agree that bilateral conjunctivitis is very uncommon and conjunctivitis is rarely referred to a consultant. Perhaps by the

time patients reach him the other eye has been affected, but it shows how blind hospital doctors can be to the highly selected nature of their workload.

When I was a student I had to learn a long list of causes of lower back pain but in practice I see about one patient a day with back pain and in most instances I don't know the cause. X-ray examination, when it is carried out, is usually negative. The back is clearly stiff and painful from a contraction of the longitudinal muscles of the spine, but I do not know what the cause of that spasm is. I can make up theories, but what good is that?

There is a great deal of medical ignorance accumulating between the general practitioners' and the consultants' range of interest. The general practitioner does not see enough cases or cannot investigate his cases sufficiently to get sound knowledge, and the consultant sees a population which has already been highly selected. Why is there no feedback to medical students? Why cannot they be taught lists of causes which bear some relation to reality rather than the gleanings of ancient textbooks?

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DEFINING PARADIGM

Sir,

"When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean—neither more nor less." How pleasant it is that Humpty Dumpty has still a disciple 108 years later in the person of Dr B. R. Barnett (September *Journal,* p. 520) who writes (p. 521): "Paradigm is here used to mean an accepted body of scientific achievements that for a time provide model problems and solutions to a community of practitioners."

Dr Barnett later admits (p. 524) to ownership of the *Shorter Oxford Dictionary.* I have only the *Concise.* Here it is laid down that a paradigm is "an example, pattern, especially of inflexion of noun, verb, etc.".

If Dr Barnett is as keen as he says "that doctors in their dealings with patients should not persist in error", he should use his dictionary more assiduously.

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BOOK REVIEWS

ON THE STATE OF THE PUBLIC HEALTH FOR THE YEAR 1977

Department of Health and Social Security

HMSO, London (1978)
129 pages. Price £2.50

The annual review of the Department of Health and Social Security is always worth reading because it provides in compact form basic information about developments in the National Health Service, not always easily found in other documents.

In the manpower section this report shows that British general practice is still failing to recruit British-born male doctors, and in 1977 increased the number of these in England and Wales only by 16. There were, however, increases in the number of male overseas doctors (153) and female doctors born in Great Britain (116); thus the total number of unrestricted principals in general practice in England and Wales increased by 263.

The total number of principals born overseas now forms 19.5 per cent of all principals. By comparison there was an increase of 881 hospital doctors including 120 new consultants. In 1977, 15 per cent of consultants were born overseas, over a quarter of all senior registrars, and over half of both registrars and senior house officers.

The report states that "a requirement to undertake at least one year in general practice as a trainee may be introduced before then [1981]" and that "although the regulations have not been introduced, the number of doctors training for general practice continues to increase by about 100 a year. On 1 October 1977 there were 941 doctors in their general practice trainee year and the number of trainers rose to over 1,500.

It is clear that the training programme is now reasonably in balance because the total number of those entering general practice for the first time in 1977 was 1,101.

In 1977, the infant mortality rate fell to 13.7 per thousand live births, and the perinatal mortality fell to 16.9. The standard mortality ratio has been used as the index for international comparisons and the conclusion is that the level of mortality in England and Wales puts us at the mid-point or marginally into the top half of the rank order of the selected countries.

In an interesting table on the principal causes of death in 1977 based on standard mortality ratios, taking 1968 as 100, the main diseases in which there has been a deterioration include "carcinoma of the oesophagus, 114; other malignant neoplasms, 111; and of the trachea, bronchus, and lung, 110".

Other diseases in which mortality ratios have deteriorated include aortic aneurysm, 118; cirrhosis of the liver, 118; and nephritis and nephrosis, 117.

Among the conditions in which there have been the greatest and most important improvements are influenza, 24; complications of pregnancy, childbirth, and the puerperium, 35; and tuberculosis of the respiratory system, 34.

Other interesting improved rates include bronchitis, emphysema and asthma, 63; suicide and self-inflicted injuries, 82; and peptic ulcer, 88.

Dominating the causes of death is ischaemic heart disease which still forms more than a quarter of deaths from all causes, and in which there has been virtually no change in the standardized mortality ratio.

New claims for sickness and invalidity benefits showed a reduction of five per cent during the year and it was reported that the output of medical students exceeded 3,000 for the first time.

Laboratory services continued to increase, and the rate of increase in 1971 to 1976 averaged six per cent a year, with 8.6 per cent increase for chemical pathology. Simultaneously, the use made by radiology services increased by another 10 per cent in 1976.

D. J. PEREIRA GRAY

MEDICAL TEXTBOOK REVIEW 3RD EDITION

Victor Daniels and Steven White

Cambridge Medical Books
Cambridge (1979)
121 pages. Price £1

The compilers of this paperback are to be congratulated on their idea. Short reviews of about 1,000 medical textbooks, pre-clinical and clinical, are