Health for All by the Year 2000

Sir

I refer to the letters from Dr R. Peppiatt (March *Journal,* p.185) and Dr R.de Soldenhoff (September *Journal,* p.604).

As one who has been on the sending and the receiving ends of the exchange of unwanted drugs between here and overseas I am very sorry that two interested and caring doctors should apparently disagree on this very important issue. It may cause other senders to be disillusioned and receivers to be considered ungrateful and incompetent. I am sure that neither is correct.

Dr Peppiatt depended entirely on receiving drugs from this country when he worked in a hospital in Africa. He must be aware of the heartbreak of being without essential and lifesaving drugs and of the arrival of others, useless in the local situation. Dr de Soldenhoff has had the same experience which he has stressed at the expense of discouraging people from sending what is needed.

I would plead for doctors to continue to send what they can, but first to telephone one of the local agencies to ask what is acceptable. One such is Clinicare based in London; telephone 01-328 9442 (mornings). Patients reaching hospital in deprived areas are mostly suffering from gross disease and need heroic treatment. Many severe infections need multiple antibiotic treatment and the arrival of usable antibiotics is a godsend.

When you, or your families or patients, have to walk ten or more miles in tropical rain or scorching heat, hungry and ill, then sit all day waiting to receive, say, ten aspirins (if you are lucky) then stop sending, for your need is as great as theirs!

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Medical Ethics—a Survey of General Practitioner Attitudes

Sir,

Drs Dunn and Shaw limit their survey on medical ethics to matters of fertility control and death (December *Journal,* p. 163). But ethics, our perceptions of right and wrong, are not limited to the ins and outs of life. Religious groups have stimulated debate on some issues but political debates on private practice and priority of care for different patient groups are also ethical questions. Appropriate prescribing, drug promotion, cigarette advertising, the seat belt law, community funding of preventive health measures—all have a major ethical component.

By limiting the range of questions they limit the range of answers. As well as asking 'Do you consider oral contraception ethical?' they should have asked 'Do you consider it ethical to refuse contraceptive advice?'

If the question is vague as in 'Would you like to see more precise definition of specified circumstances (for abortion)?' then the answers are going to be open to misinterpretation.

Where the questions are too few or too narrow they will not reflect the true attitudes of the respondents in practice. For instance, rarely is the question as simple as wanting an abortion because the 'mother's career is threatened'. There are inevitably other factors even if not always perceived by the doctors.

Where the question is meaningless as in 'Does a person have the right to take his own life?' respondents may substitute a meaningful question such as 'Does a person have the right to ask for assistance in taking his own life?'

The question may be technical, for instance 'Are the criteria for brain death reliable?' The ethical question implied is 'reliable enough to switch off the respirator or to remove the heart and kidneys?'

I doubt the value of a statistical analysis of a survey of 500 people where the 200 non-respondents are ignored.

Finally an unfortunate error in the summary stated that a majority of doctors had reservations about AID and post-coital contraception, when in fact a minority was the case.

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Manipulations of the Cervical Spine—a Pilot Study

Sir,

The article by Howe, Newcombe and Wade (September *Journal,* p. 574) contains some methodological faults which make their conclusions untenable.

Although the assessing doctor was 'blind' to the therapy they received, the patients were not 'blind' and immediately a source of bias between the two groups in treatment is obtained.

There is absolutely no point in comparing immediate improvement in symptoms and signs in the manipulation group with the control group, if the control group did not receive any particular form of therapy in the immediate period. The only relevant information is that concerning their subsequent clinical course and the trial clearly shows no significant difference in regression of symptoms between patients in the control and the manipulation groups.

There are numerous reports in the literature of neurological damage following cervical manipulation although, thankfully, it is a very rare consequence. However, your patient may be the next one and I think we should be absolutely clear on the benefits of cervical manipulation before we all start practising it, as suggested by the authors of this article.

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Medical Records

Sir,

I am writing to recommend a simple method of improving medical records by summarizing all the laboratory information available on each patient. Our practice is currently going through the laborious task of preparing note summaries in readiness for computerization. This task is being tackled by different partners in different ways as we have a personal list system. I suspect the method that I shall outline is already employed in some way by some of your readers. However I have been impressed by the number of general practitioners I have spoken to who have not attempted anything like it and who have thought the idea helpful and interesting.

This task can quite easily and safely be undertaken by a medical secretary. All laboratory and x-ray results are separated from the rest of the hospital letters. The reverse side of the summary card is used and in the left hand column a list of all types of laboratory investigation carried out is made and along the horizontal line, in chronological order, the month and year is recorded each time that investigation has been carried out. A positive or interesting result is ringed and a negative result not ringed. I would suggest that all negative laboratory results can then safely be pruned from the notes.

The result is an easy-to-scan profile of all laboratory investigations on that patient, often giving in itself a clue to the major problems of the patient. A large collection of unringed dates may be quite suggestive of the true nature

of the patient's problem.

It is also a method which ultimately saves money by preventing unnecessary repeat requests for x-rays and other laboratory tests which would otherwise lie buried in the middle of the notes without the doctor or the patient being certain as to when or what was done.

As yet I have found no software that would be able to present this information on a screen or part of a screen and I hope to stimulate discussion by present computer users as to the value of this system.

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Primary Health Care in Industrialized Countries

Sir,

Dr Hannu Vuori asks in his letter (December *Journal,* p.827) which myth I am writing about and what exactly I am claiming.

I am claiming that it is completely misleading for a representative of the World Health Organization to suggest that primary care in Sweden is basically carried out through community health centres when, on his own admission, in 1981 55.8 per cent of all primary care visits took place in hospital outpatient departments. He makes no mention of private consultations carried out by private specialists and general practitioners, or of full time hospital doctors and industrial medical officers who also provide primary care: all these make up perhaps a further 10 per cent. Of course, I accept that official policy is for each community to have a health centre which should provide primary care: as Dr Vuori has stated, 734 centres out of the 775 planned by 1985 have already been built. But the fact remains that even now they do not, in reality, carry out the main burden of primary care.

Furthermore, particularly since the Alma Ata Conference of 1978, all pronouncements from the World Health Organization have rightly stressed the importance of the acceptability to the patient of any primary health care system and have made this issue one of the essentials of good primary health care.

What can be seen from Sweden is that most patients still prefer—for whatever reasons—to use hospital outpatient departments or private practice. There is a great deal of difference between theory and reality.

This is the myth that I think Dr Hannu Vuori is in danger of perpetuating. Without an honest assessment of what actually happens in any country, there can be no useful international cooperation or exchange of ideas and little chance of learning from each other's successes and failures. It is absolutely imperative that an independent body such as the World Health Organization should be able to disentangle what actually happens from what is intended to happen.

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Use of a Nebulizer for Acute Asthma

Sir,

I read with interest Dr Jenkinson's article (November *Journal,* p.725).

Some practitioners may wish to know which nebulizer to buy for their practices, and I recommend that each partner purchase his own footpump nebulizer costing £25 for his car,[1] and that the surgery has one electrically driven nebulizer costing about £100.

Details of the footpump nebulizer are available from Cameron-Price Medical Division, Birmingham Factory Centre, Kings Norton, Birmingham B30 3HL. The electric compressor nebulizer is available from porta-Neb, Medicaid Ltd, Pollard House, Lake Lane, Barnham, Chichester, Sussex.

In our practice all partners have their own footpump nebulizers for emergency management of asthma particularly at night or weekends in the home, and there is a Health Centre electric nebulizer for asthma attacks in the surgery.

Patients who wish to purchase their own nebulizers are advised first to buy a mini Peak Wright Flow Meter, costing £12. They are allowed to purchase a nebulizer later if it is really necessary.

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Reference

1. Masters NJ. An inexpensive nebulizer for asthmatic patients. *Practitioner* 1983; **227:** 1733–8.

Sir,

I was interested to read the paper by Dr D. Jenkinson (November *Journal,* p.725). This is an excellent short paper promoting the use of nebulizers in general practice, but Dr Jenkinson has omitted to mention when *not* to use a nebulizer. Among other contraindications is hypoxaemia, when present or suspected.

It has been shown that beta-adrenoreceptor agonists tend to reduce the partial pressure of oxygen in arterial blood (p_aO_2) by reversing pulmonary arteriolar constriction and restoring perfusion to underventilated alveoli. Thus, if these drugs are administered via a nebulizer to hypoxaemic asthmatics without preoxygenation, the p_aO_2 may fall to a dangerously low level.

If hypoxaemia is present or suspected, the patient should be given oxygen before a beta-adrenoreceptor agonist is administered via a nebulizer.

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Chlamydial Cervicitis

Sir,

In reply to Dr L. J. Southgate (February *Journal,* p.118) reliance on a high index of suspicion and immediate and proper empirical management is less likely to miss active cases of chlamydial cervicitis in general practice than testing for antibodies. This is because a serum IgG antibody level of 1/16 points to an infection at some time but not necessarily one that is current. More than one such test is needed in order to show a rising titre.

This was exemplified in my paper (November *Journal* p.721). Two of five women were both isolate and serum antibody positive. In one of these, the antibody level when *Chlamydia trachomatis* was isolated was only 1/2 reaching 1/64 after a week.

I understand from Dr G. L. Ridgway, Consultant Pathologist, Clinical Microbiology, University College Hospital London, who is an authority on this, that the test for chlamydial antibodies in cervical secretions is insensitive and unreliable. One problem is that it is uncertain to what extent the antibodies are local or from serum transudate. At present, the standard acceptible technique for the diagnosis of a transmissible chlamydial genital infection is by cell culture for inclusions.

Dr Southgate's comparison between the management of gonorrhoeal and chlamydial genital infection is fatuous, because the diagnosis of the former can be achieved by routine general practice procedure. In this context, empirical treatment should not be even envisaged.

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