Ethical guidelines for sick doctors

Sir,
While wishing to thank Dr Masters for raising the subject of ethical guidelines for sick doctors (Letters, September *Journal*, p.428), I find his proposals show little thought to the processes at work before the consultation occurs.

Most general practitioners shrug off the majority of their symptoms as harmless. If the symptoms do gain any importance the doctor is likely to prescribe for himself rather than bother a busy colleague. By the time outside advice is sought the disease process will either be resolving or else have progressed to a potentially avoidable extent.

Spouses may wish that their sick doctor husband or wife would seek outside professional help but these wishes are likely to be overruled because of the doctor's 'higher' knowledge of such matters.

Forcing general practitioners to register outside their own lists will not ensure that they seek advice.

General practitioners should spare a thought for their colleague's health all of the time. If one is alert to the possibility of illness in a colleague one will undoubtedly increase the likelihood of helping.

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12th WONCA Conference

Sir,
In his article concerning the successful 11th WONCA Conference in London (August *Journal*, p.387) E.J.M. writes, 'At the closing ceremony the next meeting in Jerusalem in 1989 was mentioned' and goes on somewhat laconically to ask, 'but Jerusalem was a long way away, and why should one travel?' The answer to this question is in fact to be found in the last paragraph of the same article where E.J.M. points out that in London 1300 doctors from 47 countries, some of them deeply divided politically, came together to discuss common problems, adding 'the ideas and enthusiasms shared would have a much greater effect on the world than many summit conferences'.

None of the achievements of the WONCA conference in London would have been possible had not the vast majority of participants chosen to travel — in some cases very long distances indeed — in order to be present. That is why it is our sincere hope that, just as they travelled to London, many general practitioners and family physicians from countries all over the globe, regardless of their political divisions, will elect to travel to Jerusalem in May 1989, to expand and deepen the invaluable international intercourse between doctors of many lands which E.J.M. so rightly acclaims.

Each and every delegate, from wherever he or she comes, will be made most welcome in Jerusalem in 1989.

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Asthma and whooping cough

Sir,
Since I carried out a study on the long-term respiratory sequelae of whooping cough,[1] I have been intrigued as to why there were significantly more children with asthma in the whooping cough group than in the control group (Table 1). Furthermore, only 3.5% of the 86 asthmatics in the whooping cough group had been fully vaccinated compared with 29.1% of the 55 asthmatics in the control group. When the decision to vaccinate or not to vaccinate had to be taken by the parents, the family history would probably already be known. I have recently looked at the family history of the children who eventually developed asthma. Significantly more asthma children in the whooping cough group had a family history of compared with the asthmatics in the control group (Table 1).

Table 1. Relationship between family history of asthma and whooping cough.

	Total no. (%) of patients	No. (%) with family history of asthma
Whooping cough group with asthma	86 (*10.6*)	40 (*46.5*)
Non-whooping cough group with asthma	55 (*6.8*)	15 (*27.2*)
Whooping cough group without asthma	727 (*89.4*)	129 (*17.7*)
Non-whooping cough group without asthma	758 (*93.2*)	127 (*16.8*)

There was no significant difference in the family history of asthma in the two groups when considering children who did *not* suffer from asthma. This evidence suggests that a family history of asthma is being used as a contraindication to pertussis vaccination.

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Reference

1. Swansea Research Unit of the Royal College of General Practitioners. Respiratory sequelae of whooping cough. *Br Med J* 1985; **290**: 1937-1940.

Benefits of the portable haemoglobinometer in group practices

Sir,
The central haematology laboratory serving our two district health authorities receives about 20 000 blood count requests a year from general practitioners. We recorded the results of 800 consecutive requests for blood counts from general practitioners — 183 of the samples (23%) had a low haemoglobin level — less than 130 g l^{-1} for males and 124 g l^{-1} for females. In the remaining 617 samples the laboratory detected abnormalities in 92. A blood film examination was carried out on these samples and the following abnormalities were recorded:

1. An increase in mean red cell volume (MCV). The normal range for the laboratory is 81–99 fl and of the abnormal samples 29 had an MCV in the range 100–104 fl and four in the range 105–110 fl. Three of the latter four patients had a known cause for their macrocytosis — alcohol, cytotoxic drug therapy or a haematological malignancy.

2. A decrease in MCV. Eleven samples had an MCV in the range 77–81 fl and two in the range 70–76 fl.

3. An increase in the total white blood count (WBC). The normal range for the laboratory is 4.0–11.0 x 10^9 l^{-1}.[1] Excluding samples from patients known to have glandular fever there were 29 samples with a WBC in the range 11.1–14.9 x 10^9 l^{-1} and three in the range 15.0–18.5 x 10^9 l^{-1}. Blood film examination showed that the leucocytosis