fessor Kay's comment (ref. 2 in our article) 'there have been no reports of British epidemiological studies on this subject in the past two decades'. This was further supported by Dr McDonald of the Institute of Psychiatry in his publication of 1986 (ref. 9).

We compared our results with a study on depression in London published in 1986 which is more recent than the study in London quoted by Dr Ames. Our paper was submitted for publication in 1986 and, as Dr Ames suggests, could not possibly have referred to the studies in Liverpool and Scotland, published in 1987.

I maintain that the clinical diagnosis of depression should not be made on questionnaire results alone. Professor Goldberg and associate (ref 17) appear to support my view.

I thank Dr Ames for his support for further epidemiological studies and for informing me of the recent publications on the subject.

I wish to report a printing error in the text. A sentence in the second paragraph of the discussion should read: 'However, *their* study was selective and did not include those patients...', rather than *'our* study' which confused some readers who brought the error to my attention.

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Bacteriology of a rural practice

Sir,

I was most interested to read Ditchburn and colleagues' retrospective bacteriology survey (March *Journal,* p.110). However, I do not entirely agree with their proposed antibiotic regimen.

Most general practitioners are faced with having to prescribe an antibiotic before bacteriological results are available, based on the most likely causative organism. With respect to urinary tract infections, in this study *Escherichia coli* and *Klebsiella pneumoniae* were the commonest causative organisms, *E. coli* being six times commoner than any other organism. As 95% of these organisms were sensitive to nitrofurantoin and 79% to trimethoprim it would appear that either drug would be a reasonable choice to cure a majority of patients while awaiting bacterial culture results.

The advantage of trimethoprim over nitrofurantoin is that it is well absorbed, attaining high concentrations in blood and other tissues, and therefore effective in patients at risk of developing an ascending pyelonephritis. Trimethoprim is one of very few antibiotics which penetrates prostatic tissue in therapeutic concentration and thus is very useful in this difficult therapeutic area.[1]

Either nitrofurantoin or trimethoprim may safely be used for long-term prophylaxis in children with anatomical abnormalities of the urinary tract which predispose to infection — the commonest organisms involved again being *E. coli* and *K. pneumoniae.*[2] The high blood concentrations achieved with trimethoprim may confer advantages and tolerance appears to be better than with nitrofurantoin. In contrast, cephalosporins are not suitable for long-term prophylactic use. Unfortunately, the authors give no indication of the sensitivity of *E. coli* to cephalexin in their series, although they recommend its use.

In bacterial upper respiratory tract infections, trimethoprim has recently been shown to be as effective as amoxycillin in a prospective, randomized double-blind trial in general practice.[3] It penetrates sputum well and is an effective alternative to the penicillin group.

Trimethoprim is usually ineffective against *Pseudomonas aeruginosa* and *Neisseria gonorrheae,* neither is it recommended for use in pregnancy. With these provisos it remains a safe and effective antibiotic in the general practitioner's armamentarium.

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2. White RHR. Management of urinary tract infections. *Arch Dis Child* 1987; **62:** 421-427.
3. McGuinness BW, Cooper J, Kent PL. Trimethoprim versus amoxycillin for upper respiratory tract infection. *Practitioner* 1986; **230:** 905-908.

Sir,

Dr Ditchburn and colleagues are to be congratulated on their assiduous retrospective six year study of bacteriology in rural general practice (March *Journal,* p.110). My surprise on reading this article — and I suspect that it also surprised the authors — was the relatively high percentage resistance of urinary tract pathogens to trimethoprim.

One reason for this may be that they analysed all positive urine cultures together whether the samples were obtained from patients with acute or chronic problems. The latter tend to have repeated cultures from which may be grown colonies of bacteria of unusual genera and resistance to antibiotics. In this study, culture rates of *E. coli* were perhaps less than one would expect while those of *K. pneumoniae* were perhaps higher. This again suggests an unusual predominance of chronic infection.

If the authors could separate from their figures those results derived from acute urinary tract infection and so prove their point, I should feel happier in discarding trimethoprim as my first choice in the treatment of acute urinary infection. Nitrofurantoin, which the authors suggest as their drug of choice, is more expensive, associated with more side effects and is contraindicated in the presence of renal failure.

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Sir,

We are grateful to Dr Miller for his comments on our paper. We had considered the possibility that an unusually high number of chronic infections might have been responsible for our finding of a high frequency of resistance to trimethoprim in urinary pathogens. However, this does not appear to be a significant factor. Of the 325 urinary pathogens isolated, 54 came from patients with recurrent infections caused by structural or functional abnormalities of the urinary tract. These indeed had an atypical flora — only 31% grew *E. coli* and 26% *K. pneumoniae.* Among the remaining 271 'normal' cases 68% grew *E. coli* and only 8% grew *K. pneumoniae.* The sensitivity to trimethoprim in these cases was still only 72%. This is because of the relatively high resistance to trimethoprim of all the urinary pathogens including *E. coli.* Trimethoprim resistance was present in 21% of *E. coli* strains, 45% of *K. pneumoniae* strains and 43% of *Streptococcus faecalis* strains. Thus, although Dr Miller may be right in ascribing our relatively low frequency of *E. coli* in urinary infections to abnormal cases, these do not explain most of the trimethoprim resistance found.

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Medicine in South Africa

Sir,

I read with interest Dr Donald's editorial (March *Journal,* p.97) on international aspects of general practice. The author states with some pride that 'within three

years of the College's foundation regional councils had been established in Australia, New Zealand and South Africa ... This led to the formation of independent colleges in Australia, New Zealand, South Africa..'

Medicine in South Africa is not independent, nor can it ever be under apartheid — a system in which 4.5 million whites (15% of the population) have statutory rights at the expense of the other groups, and which allows there to be one doctor for every 330 whites, 730 Indians, 1200 coloureds and 12 000 Africans.[1]

Though there may have been College links with South Africa in the past, it would seem wrong for these to be encouraged now, given the even more widespread oppression of blacks since the state of emergency in 1985. Dr Donald holds up the South African 'spin-off' as an example of the world-wide influence of the College. I believe that this gives a misleading impression of South Africa and in doing so, gives the College's tacit support for the South African system of health care.

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Reference

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Role of the pharmacist

Sir,

Sarah Cunningham-Burley's editorial (March *Journal,* p.99) made interesting reading but she fails to encompass the potential role of the pharmacist.

The pharmacist has an important part to play in the provision of primary health care but not in his current role. The chairman of the Nuffield report on pharmacy, Sir Kenneth Clucas, has recently declared that 'The dispensing role of the community pharmacist is in a state of unstoppable decline'. The reasons are manifold but may be summarized as follows. Dispensing by doctors is cheaper (25p per script in the last two years), safer, more rational, and appreciated by patients. It enhances the quality of care that can be offered and increases consumer choice and competition in the provision of services. The provision of medicines has been simplified by the limited list and is further simplified by the adoption of practice prescribing policies. The mechanical functions of counting and measuring will soon disappear too with original pack presentation and the importance of checking prescriptions is somewhat exaggerated in the present efforts to define an up-to-date role for the pharmacist. If a doctor does not know or cannot discover the clinically important information about a product then he or she should not prescribe that product.

As I outlined in my submission to the Nuffield inquiry there is a need for both revised and new roles for the pharmacist. The checking function should take place at the other end of the sequence, that is, in advising the doctor on the practice formulary, and there is merit in the district based provision of unusual products, such as toxic products, controlled drugs and appliances, on a domiciliary basis. Pharmacists could also exercise a valuable auditing function. Retail pharmacists should be allowed a wider variety of over the counter sales but this should be balanced by a requirement for more advanced clinical training and being liable for their actions.

Pharmacists are indispensable to primary care but to realize their potential they must dispense with dispensing. Above all the patient must come first; those patients who have experienced dispensing by the doctor value it highly.

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Problems in North East Thames region

Sir,

The recent 'trial' of the North East Thames region by the Joint Committee on Postgraduate Training for General Practice already had an air reminiscent of that of the Knave of Hearts in *Alice in wonderland,* in respect of the inadequacy of the evidence for the prosecution, the failure to hear that for the defence, and the general impression of 'sentence first, verdict afterwards'. All that was lacking was for the College to take up, with intemperate haste, the role of the Queen of Hearts with the cry of 'Off with their heads!' This deficiency has been duly rectified by the letter from the Chairman of Council.

This letter declaring the College's intention to 'minimize the impact of its action on trainees' has a hollow ring in the wake of the immense and irreparable harm already done by the Joint Committee's action, which the College's response has now compounded.

Some of us might regard exclusion from sitting the MRCGP as a fairly minor deprivation. But the weight of the College's condemnation is bound to maximize rather than minimize the harm to trainees. The sweeping, and totally unsubstantiated, generalizations in the Chairman's letter about 'inadequate training' and 'putting patients at risk' can only be destructive to the prospects of every one of them.

Furthermore, the statement that the College action will 'achieve a speedy resolution of the problem of standards in the Region' can only be true in one sense. Standards of conformity to required criteria will no doubt go up, but the standard of practice generally can only be depressed, as a direct result of the action of the Joint Committee and the College. The blight cast on the region is already manifest in a reduction of the numbers, and one must suppose, the quality, of applicants for training schemes, and this will duly affect partnership and practice vacancies in the course of time. The global effect on morale will be profound.

It is difficult to see how such a downward spiral, once established, could be reversed; once standards were indeed declining, at what point could the College and Joint Committee restore their favours? Or do they envisage a wholesale takeover by pioneers from more virtuous regions?

The College may have successfully demonstrated to the government its enthusiasm for policing the profession, but has hardly given a convincing demonstration of mature judgement or consideration for the consequences of its actions. If this is the kind of 'self-regulation' that it proposed, perhaps the profession would be better off under state control. One could hardly conceive of a government department initiating such an action against an entire region on the basis of allegedly inadequate records in the minority of a small sample of practices in the region.

It has been said that those who fail to learn from the mistakes of the past are condemned to repeat them. Has nothing been learned from the travails of last year, that we must now endure another battle with many casualties and no winners, except for those who will rejoice to see our house again divided against itself?

All course organizers at least will have taken note of the lesson that for future visitations they should, like the gardeners in *Alice,* ensure the roses are the right colour and assume a prostrate position in anticipation.

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