

## General practitioner obstetrics: does risk prediction work?

Sir,

The study by Reynolds and colleagues (July *Journal*, p.307) shows that a considerable proportion of pregnant women, who, according to conventional criteria, were at low risk of developing complications, did in the event develop them and were duly transferred for consultant care. This finding leads the authors to ask whether other criteria could be identified which would more accurately predict the non-occurrence of complications and so obviate the need for transfer.

To begin to answer this question, it would be necessary to know the incidence of the same complications among the women who failed to fulfil the same selective criteria. The Oxford obstetric data system could probably be dredged to yield this information.

But more fundamental is the need to measure outcome — mortality and morbidity of mother and child — in order to establish whether the women transferred were the better for the transfer, that is, whether the interventions to which they were subjected decreased the risk to babies associated with the complications. Other data give reason to suspect that they do not.

For example, official statistics<sup>1,2</sup> show specific stillbirth and perinatal mortality rates in all maternal age groups, older as well as younger, and at all parities to be lower in isolated general practitioner units than in consultant hospitals. The *British births 1970* survey showed that, using the obstetricians' own measure of comprehensive risk, specific perinatal mortality rates at all levels were highest in consultant hospitals.<sup>3</sup> In New Zealand in 1978–81 perinatal mortality rates for the 99% of births weighing 1500 g and over were significantly lowest in the least specialized hospitals.

Clearly, if the maternity service is to be organized to provide the greatest safety and satisfaction for its clients, the overriding need is for evidence to support or refute the hypothesis, hitherto untested, that obstetric management is especially valuable to babies who are at risk because their mothers have certain characteristics or obstetric experiences. Unless there is evidence to support this hypothesis, there is no point in identifying criteria which will more accurately predict the occurrence of complications. Surely the Oxford data system could be used to search out this information, if those who have access to it dare to do so?

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## Malaria prevention for travellers to west Africa

Sir,

Dr Phillips-Howard and colleagues' advice on malaria prevention for travellers visiting west Africa (*May Journal*, p.226) is open to dispute principally because of their recommendation to use chloroquine weekly for prophylaxis albeit in combination with daily proguanil. In Zimbabwe we have, rightly or wrongly, blamed the increasing resistance of *Plasmodium falciparum* to chloroquine in established cases of malaria on our recommending its use for prophylaxis over the years: this is now discouraged here because of the false sense of security it may give and because it may further promote chloroquine resistance.

The College of Primary Care Physicians of Zimbabwe in conjunction with the Blair Research Laboratory in Harare recommend pyrimethamine plus dapsone for prophylaxis (Deltaprim, Wellcome) or amodiaquine for hypersensitive patients. For adult treatment they recommend four tablets of chloroquine base (150 mg) at once, then two tablets in six hours and two daily for two more days. Even in chloroquine susceptible malaria the parasites may remain in the blood for three days and the temperature high for at least a day after treatment. If it still remains elevated after this, one of the following courses is given: (1) a single dose of three tablets (pro rata for children) of pyrimethamine/sulfadoxine (Fansidar, Roche); (2) quinine 600 mg three times a day with tetracycline 500 mg three times daily for seven days (not for children under eight years old); or (3) two tablets of co-trimoxazole (pro rata for children) twice a day for five days.

I would like to make a special plea to doctors in the UK: please do not prescribe Fansidar for prophylaxis, not because of the risk of serious skin reactions or other side effects, but because to do so might increase the strains of *P. falciparum*

already suspected of being resistant to this drug combination.

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*There is no perfect answer to malaria prophylaxis and treatment and recommendations from British authorities and from the World Health Organization do differ from the recommendations of doctors working in countries such as Zimbabwe. For example, doctors here generally consider proguanil to be a useful drug, whereas amodiaquine is not recommended because of the risk of agranulocytosis. Perhaps mosquito nets will regain their popularity as they may be more cost effective than drug prophylaxis in east Africa. (Ed)*

## HIV infection: ethical problems for general practitioners

Sir,

I would like to expand on several points in Morris Gallagher's excellent article concerning ethical problems for general practitioners dealing with patients with human immunodeficiency virus (HIV) infection (*September Journal*, p.414).

Although he is concerned about the issue of confidentiality he perhaps does not go far enough. In family medicine, a case could be made for absolute confidentiality as practised by clinics for sexually transmitted diseases where medical information is never divulged, regardless of the reasons, should the patient not agree. Clinic doctors are faced daily with HIV patients who admit to unprotected sexual intercourse and, as difficult as this knowledge may be for doctors to hear, absolute confidentiality guarantees trust by the patient. The majority of people are open to persuasion and although patients who ultimately refuse to follow guidelines to protect their partners cause great difficulty for the doctor, perhaps the greater good is to remain silent. When patients suspect that their doctor may eventually leak such vital information they will simply cease to confide in him or her.

Dr Gallagher's objection to the commercial intrusion of insurance companies could also be carried further. If general practitioners as a profession decided not to provide medical reports on their patients for insurance companies, the companies would be forced to rely on more appropriate sources such as the patient's own report, with recourse to independent medical opinion where it was deemed necessary. Only then would patients' trust