tions such as medical audit have limited or transient effects.

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Voluntary euthanasia

Sir,
Doctors on the medical ethics committee of the Order of Christian Unity, which represents all mainstream Christian denominations, discussed Dr Bliss's paper on voluntary euthanasia (March *Journal,* p.117) at their meeting in June.

The committee believes that doctors should never consider killing as an option in medicine, no matter how attractive (or cost effective) this may appear as a solution). The first rule of medicine, *primum non nocere* (first do no harm), must continue to be the law under which the profession functions.

Sadly few medical students now understand the importance of the Hippocratic oath, or its updated version in the declaration of Geneva (1948). Is there not a case for reintroducing some form of acceptance of Hippocratic principles after qualification as a doctor?

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What makes patients consult?

Sir,
The question of what influences patients in their decision to consult a doctor is a fascinating one. The paper by Wyke and colleagues (June *Journal,* p.226) confirms that the perceived severity of a symptom is a crucial factor in this decision to consult. I am sure that most general practitioners would agree with this finding. In their study of respiratory illness in children, factors such as the mother's educational level and the number of children in the family under 12 years of age, which had been shown to be important in previous research, did not influence the decision to consult. The authors say that this implies that coughs were worst among the more materially deprived children and that this finding requires further investigation.

Having worked in a deprived area for a number of years, I have noticed that patients from educationally poor and socially deprived backgrounds are sometimes not very good at judging the severity of illness, particularly in their children. The link between social factors and the severity of the symptom does not seem to be in the objective severity of the symptom but in the subjective perception of the severity. Parents of lower socioeconomic status may perceive a cough as worse, and this may explain the findings of the study.

The worrying thing is that the inaccurate perception is not always in the safe direction of perceiving the cough as more severe than it is. I have visited children from deprived backgrounds with 'a bit of a cough' to find a severely ill child who has required immediate admission to hospital. In one recent case the child was lying relatively quietly and not interrupting the social life of the family which probably accounted for the lack of parental anxiety. The parents were terribly upset when they realized how ill their child was, my intervention having altered their perception of the severity of the illness.

By the objective criteria of the medically trained person, patients do consult 'inappropriately'. By their own criteria the decision to consult or not to consult is almost invariably entirely appropriate. Patients' perceptions are different from ours, and in the case of socioeconomically deprived patients, they may be very different. Not necessarily better or worse, but different.

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Sir,
We were interested to read the paper by Wyke and colleagues (June *Journal,* p.226) which suggested that severity of symptoms and changes in children's behaviour were prime factors influencing parents' decision to consult their general practitioner.

It was not clear whether or not the interviewer was blind to the interviewee's consulting status. This is of crucial importance because, quite apart from identifying potential sources of error on the part of the recorder, careful consideration must be given to the more problematic but well documented effort after meaning[1] which seeks justification for behaviours such as consultation. Similar and equally damaging is prestige bias, whereby people with a strong need for social approval will give answers which they believe will tend to place them in a more favourable or reasonable light.[2] Rather than the perceived severity of symptoms, it seems much more likely that anxiety about the seriousness and meaning of such symptoms influences consultation behaviour.[3] The authors' explanation of inconsistencies in decision making and predicted probabilities actually lends credence to this argument.

An individual's response to any perceived threat, however small, depends on the experience that precedes and surrounds it. Collapsing, in a non-explicit way, the social situation, personal history and prior self-management strategies into a single measure means that there is no way of telling which of the factors that influenced the z-scores account for the decision to consult. Social factors were not incorporated into the model but have been shown in numerous studies to affect consultation behaviour.[4] It is therefore possible that demographic variables and perception of symptom severity influence the decision to consult through a third variable which perhaps did not feature in this research. While it seems eminently reasonable to derive a model of behaviour from this information it is quite another to attept validation using the same data. Validity can only be tested prospectively on a different data set and at best, Wyke's 'inexpensive ploy' may indicate reliability but at worse proves neither.

Finally, studies into the decision to consult for specific symptoms do exist;[5] there is, for example, evidence that patients' consultation rates for dyspepsia vary substantially from practitioner to practitioner.[6] The authors conclude from their study that a more fruitful relationship between doctor and patient will result from understanding the process by which the decision was reached. This is obviously true but the patient's agenda is largely made up of their health beliefs and expectations which in turn are influenced by a lifetime's experience. General practitioners struggling with their biopsychosocial triangles and trying to understand what prompted a particular consultation may find it more appropriate and possibly more effective to examine the parents' personal and family concerns over the impor-

tance of their children's symptoms.

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The inflammatory cervical cancer

Sir,
The paper by Kelly and Black on the inflammatory cervical smear (June *Journal,* p.238) makes fascinating reading, since the investigation of these smears in the community always presents a problem.

It would have been interesting, however, to have had more details of their management of chlamydia infection. It is not clear if they treated only the infected women, or ensured that their partners (and all others in the chain of sexual contact) were also investigated and treated. Unless an infected woman is celibate at the time of the smear, she will have a partner from whom she caught the infection, or to whom she has passed it on. Unless he too is treated she will have been reinfected by the time of her repeat smear. Were follow-up chlamydia cultures performed?

Treatment with tetracycline in the absence of proof of infection must surely be open to question, if only because tetracycline is liable to provoke a further infection with candida, and cause more inflammation on the smear. If sexually transmitted cervicitis is suspected but not proven, it may be helpful to refer the couple to a department of genitourinary medicine, so that non-chlamydial non-specific urethritis can be detected by the presence of pus cells in the man's urethra and all contacts traced and treated as necessary.

As the human immunodeficiency virus epidemic spreads, our patients will become increasingly concerned that the presence of 'minor' sexually transmitted diseases may mean that they have also been exposed to far more dangerous pathogens. They will demand accurate diagnosis of infections, and blind treatment may obscure an extremely important medico-legal point.

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Sir,
Drs Kelly and Black (June *Journal,* p.238) are to be thanked for their study which complements larger community based studies carried out before[1] and after[2] theirs. I must, however, dissent strongly from their hesitancy about whether to treat a *Chlamydia trachomatis* infection, which they justify by citing 'the potential adverse effects of a lengthy course of tetracycline therapy'.

A week's course of tetracycline (preferably doxycycline), or of erythromycin if the patient may be pregnant, is sufficient to cure most chlamydial infections (Robinson AJ, manuscript in preparation), and has a low incidence of side-effects. The 'blind' use of metronidazole which they advocate is more likely to upset patients. The male partner(s) will also need to be treated, for their own benefit and to prevent reinfection of the female. The doctor who allows a proven chlamydial infection (probably asymptomatic) to persist in a female patient is laying her open to the risk of pelvic inflammatory disease and infertility, and laying himself open to a charge of negligence.

The authors are also uncommonly fortunate in having facilities for diagnosis of chlamydia, and for specimens to reach the laboratory within three hours. Most general practitioners with a patient in whom a sexually transmitted infection is suspected would do better to refer to a department of genitourinary medicine, which will offer their patient the advantages of immediate microscopy, comprehensive testing for possible pathogens, and discreet assistance in the tracing of contacts. I write as a general practitioner who is also a clinical assistant in genitourinary medicine.

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Race, ethnicity and general practice

Sir,
The editorial 'Race, ethnicity and general practice by Ahmad and colleagues (June *Journal,* p.223) highlighted some important interactions between race and ethnicity and general practice. However, certain assertions were made which although they may be true in the narrow context of the United Kingdom are certainly not generally true.

The concept of race is described in negative terms but in other parts of the world, particularly in central Europe and Turkey, the perception of belonging to a particular race may be something that a person values. My experience is mainly in the context of Turkey where belonging to a certain race means that one has certain group and personal values, and that one conforms to certain cultural norms. This is a far more powerful perception than that defined by Ahmad and colleagues where race is referred to in terms of superiority and inferiority.

The problems of immigration in the UK are presented as relating to the fact that many of the immigrants in the post-war period came from ex-colonies and were therefore used to being of an inferior status to British people. This may be a contributory cause in the UK, but a very similar situation pertains in Saudi Arabia, where I and many of my colleagues have experienced blatant racial, financial and religious discrimination, and where neither side has had a colonial relationship with the other.

Discrimination in employment is also referred to in the editorial. It is true that many immigrants have come to the UK to do jobs that the native British population were unwilling to do. However, where there has been a shortage of skilled labour, immigrants have also filled jobs which are highly regarded by the native population, and where the income is significantly above the mean for the country, such as jobs in the nursing and medical profession. I would agree that within these professions there has been discrimination against immigrants, but in absolute terms people coming into these jobs are better off than many of the people of the native population.

Having lived in five countries and having experienced discrimination in at least two of these countries, I realize that in a rich, powerful community where there is work which the native population does not wish to do, workers are recruited from a less dominant poorer community and these people have a lower social, financial and cultural status. I would agree with the main thrust of the editorial that the care of these people anywhere in the world presents a challenge to the primary care