

mutual incomprehension is far from inevitable. Indeed, Popper demonstrates that in science competing paradigms may continue side by side for long periods of time, and that new paradigms do not obliterate old ones, but rather incorporate them into more successful models.<sup>7</sup> Although the variously constructed models for the health service are political rather than scientific, the principle of adaptation and improvement rather than of conflict, victory and defeat, holds.

Our papers were intended to offer the best available way out of what seemed to us to be the impasse of National Health Service general practice in the mid-1980s.<sup>4-6</sup> Hart describes '...the old ramshackle independent professional paradigm', and chronicles the sad consequences of 30 years of professional burnout in the Upper Afan Valley since 1961.<sup>1</sup> It may be timely to remember that prior to 1990 there were a number of perceived crises in the NHS. To suggest that those of us who sought to vary the arrangements for the NHS that were then extant, were in some way wilfully damaging a sound working model of public service on the basis of a speculative model of market economics, is to misremember history with a vengeance.

The successful future of the NHS will demand not the collision of paradigms, but what Handy describes as the management of paradoxes.<sup>8</sup> General practice has in the past been fairly successful in managing three quite different and mutually contradictory models of medical care — the biotechnical, the biographical and the proactive. Now the challenge is to reconcile the new contractual accountabilities of a managed care model with the moral obligations of a professional public service.

I realize that in prolonging this correspondence I risk the danger of this exchange of letters being seen as no more than a spat between grumpy old men. But I share with both Hart and Gray a sense of the importance of clarifying the history of events and ideas. One of the consequences of this correspondence has been to provoke me to re-read what I wrote and published a decade ago. Such reading is rarely an unmixed pleasure. However, I take courage from the writer Saul Bellow. In the preface to a recent collection of his own past essays he writes about the relative discomfort of re-reading ones own past pronouncements.<sup>9</sup> He concludes drily that it gives great satisfaction '...to have rid oneself of tenacious old errors. To enter an era of improved errors.'<sup>9</sup>

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## Prevention of end stage renal failure

Sir,

Cairns and Woolfson have written an important editorial on the current potential for slowing the rate of progression of renal failure (November *Journal* p.486). However, while they discuss early detection of at-risk adult patients with hypertension, diabetes, proteinuria or haematuria in primary care, they omit to mention detection of the at-risk child.

Thirteen per cent of adults in Europe accepted onto renal replacement programmes in 1992 had pyelonephritis (European dialysis and transplant association renal replacement register, unpublished data). A considerable proportion of these cases will have arisen from processes in childhood. These processes include coarse renal scarring associated with infection in the presence of urinary reflux, almost certainly beginning in the first two years of life.<sup>1</sup>

Clinical and experimental evidence strongly suggest that the rapid introduction of antibacterial treatments can limit or prevent development of renal scarring.<sup>2-8</sup> In other European countries such as Sweden considerably more attention has been paid to swift detection and treatment of infant urinary tract infections than in the United Kingdom, and although ascertainment bias may be a problem, it appears that there is a lower prevalence of renal failure associated with urinary infection in childhood in Sweden than in the UK.<sup>9</sup> Urinary infection is common in early childhood, but nonspecific in its presentation. Further epidemiological studies are required to define the antecedents of chronic pyelonephritis in adult life, and the exact incidence and proportion of children with infection at risk of renal damage. Meanwhile, failure to investigate promptly urinary tract infections in chil-

dren and to arrange follow up and prophylactic antibiotics appears to be contributing to avoidable renal damage in the UK.<sup>10</sup>

Before appropriate action can be taken the diagnosis must be considered, and inclusion of this cause of avoidable end stage renal failure in editorials and review articles will help to keep it in mind.

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## *Chlamydia trachomatis*

Sir,

Thompson and Wallace report finding a 3% prevalence of positive monoclonal antibody tests for *C trachomatis* in 145 asymptomatic women aged between 15 and 29 years presenting to their general practitioners for routine cervical cytology (letter, December *Journal*, p.590). They do not quote test sensitivity or specificity and it is therefore impossible to estimate positive and negative predictive values. In simple terms, we do not know how many infected or uninfected women were wrongly identified by false negative or false positive tests.

The recommendation that general practitioners screen for *C trachomatis* in 'a selected population on the basis of age