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.[7] 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.[4-6] 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.[1] 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.[8] 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.[9] He concludes drily that it gives great satisfaction '...to have rid oneself of tenacious old errors. To enter an era of improved errors.'[9]

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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.[1]

Clinical and experimental evidence strongly suggest that the rapid introduction of antibacterial treatments can limit or prevent development of renal scarring.[2-8] 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.[9] 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 children and to arrange follow up and prophylactic antibiotics appears to be contributing to avoidable renal damage in the UK.[10]

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

and contraceptive method, regardless of the presence or absence of symptoms' is confusing and needs clarification. The term screening is only appropriately used when applied to the testing of asymptomatic women with no clinical evidence of infection. When symptomatic women or women with clinical evidence of infection are to be tested, the issue becomes one of investigation rather than screening.

Women at highest risk of chlamydial infection in Canada are sexually active women between 15 and 25 years of age who use non-barrier contraceptive methods.[1] Additional risk facors include intercourse with two or more partners per year, a new partner within the preceding year, low socioeconomic class, intermenstrual bleeding, cervical friability and purulent cervical discharge.[1]

Screening asymptomatic sexually active young women who have new partners and who do not use barrier contraception makes a lot of sense for Canadian family doctors. Screening asymptomatic sexually active older women in stable mutually monogamous relationships arguably makes no sense whatsoever because the probability of a false positive test is high — test predictive values are dependent on disease prevalence. Symptomatic women and asymptomatic women with clinical evidence of infection need investigation and treatment, not screening.

The possibility of a false negative chlamydia test can be virtually eliminated in asymptomatic women with no clinical evidence of infection if a gram stain of endocervical secretions shows fewer than 10 pus cells per high power microscope oil-immersion lens field. If tests are negative for gonorrhea and chlamydia, the presence of 10 or more pus cells suggests either a false negative chlamydia test or undiagnosed ureaplasma infection.[2]

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Glaucoma screening

Sir,

Sheldrick and Sharp's paper on glaucoma screening is a timely reminder of the importance of glaucoma as a cause of visual loss and the need for a national screening programme (December *Journal,* p.561).

In 1992, a postal questionnaire was undertaken of general practitioners within the catchment area of a district general hospital in North Yorkshire, in order to assess their beliefs about glaucoma screening. A total of 99 replies were received from 120 questionnaires (83%) with at least one reply from every practice. A total of 85 respondents (86%) were aware that it is possible to screen for glaucoma, while (14%) were not aware that this is possible.

Three practices reported performing some form of screening, using a variety of techniques, such as direct applanation tonometry, fundoscopy and visual field analysis using oculokinetic perimetry charts. The screening was performed by doctors, all of whom held appointments as clinical assistants in ophthalmology or who had a special interest in the eye. Diabetic patients were screened in all three practices, with other groups at risk being screened either opportunistically (one practice) or in an organized fashion.

The main barriers to screening in the other practices were reported to be lack of equipment, mentioned by 56 respondents (72%), lack of knowledge 33 (42%), a perception that it was someone else's job 32 (41%), and lack of time 31 (40%). When all respondents were asked whom they thought should screen for glaucoma, optometrists were suggested by 83 general practitioners (84%), ophthalmologists by 24%, and general practitioners by 24%. Eighty respondents (81%) said that they would consider setting up a glaucoma screening clinic if it could be shown to be of benefit.

Although there is little in the way of organized screening happening at present, most general practitioners seem willing to consider it. There findings support the view that if a national screening programme based within general practice is set up, issues concerning education and training, equipment and time must be addressed if it is to succeed.

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Living up to expectations?

Sir,

I was interested to read your editorial about the current state and status of the *Journal* (January *Journal,* p.3) and I applaud the achievements outlined. However, I would like to draw attention to one aspect of the *Journal* which I believe reflects badly on the rest of the contents: ironically, the forum for this point of view, the correspondence columns.

The content, quality and scientific worth of published letters are extremely variable. What form of control is exerted over publication in this section? Your editorial mentions correspondence only in the context of it being somewhere to publish material which cannot justifiably be published elsewhere in the *Journal.* Is this why the correspondence columns occasionally come across as a dustbin for unscientific whimsy?

A letter on cervical screening is a case in point.[1] This letter seemed manifestly unscientific, perpetuated medical mythology and reached an invalid conclusion, as has already been commented upon.[2] Publishing material such as this sits uncomfortably with a journal which 'gives scientific respectability to general practice' and which has a 'responsibility for scientific vigour'.

I accept that the correspondence columns can, and should, provoke controversy and stimulate debate. It should not, however, devalue the rest of the *Journal.*

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Sir,

Your editorial (January *Journal,* p.3) raises some interesting questions. By the yardstick of scientific quality the *Journal* makes steady progress and has obviously established itself in its field. If this should simply be its purpose then you are entitled to feel satisfied but I have reservations about whether you are adequately fulfilling the needs of the wider membership of the Royal College of General Practitioners. In its present form, *Connection* magazine is rather forlorn and in addition has left the *Journal* with an even narrower appeal. A plate of roast beef may be succulent and nutritious but without the trimmings is relatively unappealing to all but the starving.

Over the years I have been intrigued by the piles of unopened issues of the *Journal* and *British Medical Journal* of many of my colleagues and have pondered on what stimulates me to remove the wrappers. You may argue you are not prim-