Ethical guidelines for sick doctors

Sir,
While wishing to thank Dr Masters for raising the subject of ethical guidelines for sick doctors (Letters, September *Journal*, p.428), I find his proposals show little thought to the processes at work before the consultation occurs.

Most general practitioners shrug off the majority of their symptoms as harmless. If the symptoms do gain any importance the doctor is likely to prescribe for himself rather than bother a busy colleague. By the time outside advice is sought the disease process will either be resolving or else have progressed to a potentially avoidable extent.

Spouses may wish that their sick doctor husband or wife would seek outside professional help but these wishes are likely to be overruled because of the doctor's 'higher' knowledge of such matters.

Forcing general practitioners to register outside their own lists will not ensure that they seek advice.

General practitioners should spare a thought for their colleague's health all of the time. If one is alert to the possibility of illness in a colleague one will undoubtedly increase the likelihood of helping.

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12th WONCA Conference

Sir,
In his article concerning the successful 11th WONCA Conference in London (August *Journal*, p.387) E.J.M. writes, 'At the closing ceremony the next meeting in Jerusalem in 1989 was mentioned' and goes on somewhat laconically to ask, 'but Jerusalem was a long way away, and why should one travel?' The answer to this question is in fact to be found in the last paragraph of the same article where E.J.M. points out that in London 1300 doctors from 47 countries, some of them deeply divided politically, came together to discuss common problems, adding 'the ideas and enthusiasms shared would have a much greater effect on the world than many summit conferences'.

None of the achievements of the WONCA conference in London would have been possible had not the vast majority of participants chosen to travel — in some cases very long distances indeed — in order to be present. That is why it is our sincere hope that, just as they travelled to London, many general practitioners and family physicians from countries all over the globe, regardless of their political divisions, will elect to travel to Jerusalem in May 1989, to expand and deepen the invaluable international intercourse between doctors of many lands which E.J.M. so rightly acclaims.

Each and every delegate, from wherever he or she comes, will be made most welcome in Jerusalem in 1989.

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Asthma and whooping cough

Sir,
Since I carried out a study on the long-term respiratory sequelae of whooping cough,[1] I have been intrigued as to why there were significantly more children with asthma in the whooping cough group than in the control group (Table 1). Furthermore, only 3.5% of the 86 asthmatics in the whooping cough group had been fully vaccinated compared with 29.1% of the 55 asthmatics in the control group. When the decision to vaccinate or not to vaccinate had to be taken by the parents, the family history would probably already be known. I have recently looked at the family history of the children who eventually developed asthma. Significantly more asthma children in the whooping cough group had a family history of compared with the asthmatics in the control group (Table 1).

Table 1. Relationship between family history of asthma and whooping cough.

	Total no. (%) of patients	No. (%) with family history of asthma
Whooping cough group with asthma	86 (*10.6*)	40 (*46.5*)
Non-whooping cough group with asthma	55 (*6.8*)	15 (*27.2*)
Whooping cough group without asthma	727 (*89.4*)	129 (*17.7*)
Non-whooping cough group without asthma	758 (*93.2*)	127 (*16.8*)

There was no significant difference in the family history of asthma in the two groups when considering children who did *not* suffer from asthma. This evidence suggests that a family history of asthma is being used as a contraindication to pertussis vaccination.

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Reference

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Benefits of the portable haemoglobinometer in group practices

Sir,
The central haematology laboratory serving our two district health authorities receives about 20 000 blood count requests a year from general practitioners. We recorded the results of 800 consecutive requests for blood counts from general practitioners — 183 of the samples (23%) had a low haemoglobin level — less than 130 g l^{-1} for males and 124 g l^{-1} for females. In the remaining 617 samples the laboratory detected abnormalities in 92. A blood film examination was carried out on these samples and the following abnormalities were recorded:

1. An increase in mean red cell volume (MCV). The normal range for the laboratory is 81–99 fl and of the abnormal samples 29 had an MCV in the range 100–104 fl and four in the range 105–110 fl. Three of the latter four patients had a known cause for their macrocytosis — alcohol, cytotoxic drug therapy or a haematological malignancy.

2. A decrease in MCV. Eleven samples had an MCV in the range 77–81 fl and two in the range 70–76 fl.

3. An increase in the total white blood count (WBC). The normal range for the laboratory is 4.0–11.0 x 10^9 l^{-1}.[1] Excluding samples from patients known to have glandular fever there were 29 samples with a WBC in the range 11.1–14.9 x 10^9 l^{-1} and three in the range 15.0–18.5 x 10^9 l^{-1}. Blood film examination showed that the leucocytosis

was always due to an increase in neutrophils.

4. A decrease in the total WBC. Four samples had a WBC in the range 2.9–3.9 x 10^9 l^{-1}. Blood film examination showed that all had a normal distribution of leucocytes and none were neutropenic.

5. A positive screening test for glandular fever in 14 samples.

6. An erythrocyte sedimentation rate of greater than 20 mm h^{-1} in five samples.

7. A platelet count of less than 150 x 10^9 l^{-1} in three samples. However examination of the blood film showed the presence of platelet clumps in all three samples indicating that the counts were falsely low.

Does the finding of these abnormalities help in the diagnosis and management of the patient? The findings of a modest increase in MCV has been used as a screening test for excess alcohol intake[2] but recently the sensitivity of this test has been questioned.[3,4] The finding of a modest decrease in MCV does not distinguish between iron deficiency and the anaemia of chronic disorders like rheumatoid arthritis.[4,5]

Our results indicate that little additional information is gained by forwarding samples with a normal haemoglobin level to the laboratory, except when glandular fever is suspected, or when bone marrow depression is likely to occur owing to a known haematological malignancy, or to drugs known to depress the marrow.

There is therefore a need for a robust and reliable haemoglobinometer that can be used by general practitioners to exclude anaemia. It should give a direct readout, be cheap and need the minimum of maintenance and calibration and the blood should not need to be diluted.

Three partners in a group practice used the Clandon/AB Leo Haemocue Portable Haemoglobinometer (Clandon Scientific Ltd, Aldershot, Hampshire) for a six-month period. The instrument uses disposable microcuvettes containing reagent in a dry form.[6] Whole blood is drawn up into the cuvette by capillary action either from a finger prick or from a sequestrene venous sample. A haemoglobin estimation can be obtained within 60 seconds. During the six-month period the instrument did not require adjustment. It was easily portable and had a rechargeable battery and a transformer with a mains plug. The results obtained were compared with those from the haematology laboratory Coulter counter and were found to agree very well (coefficient of correlation r = 0.99).

We suggest that group practices would benefit by using a portable haemoglobinometer issued by a central haematology laboratory.

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The cost of being doctor dependent

Despite ever greater funding, the National Health Service continues to ail. The two root causes are excessive consumer demand, which is fuelled by unrealistic expectations, and the complicity of the medical profession. This has led to overuse and abuse of the NHS and to essential services becoming impoverished. More and more money will not necessarily improve this situation and, by disguising it, may make it worse.

It is not difficult to explain why so many people elect to enter the doctor's door. Medicine has always had an omnipotent aura, which still flourishes, despite a greater knowledge of medical matters by laymen. Advances in medicine, such as effective anaesthesia, antibiotics and heart transplants buttress expectation, create an imbalanced view of what medicine can and cannot do, and even encourage the absurd belief that medicine can solve every personal problem. Furthermore, circumstances outside the medical sphere have conspired to ensure that the doctor is the first person from whom to seek the sort of help that was once freely available elsewhere. The early dispersal of families means advice and knowledge are less likely to be handed down. The cult of the individual rather than the community leads to surreptitious loneliness. Religion is unfashionable; congregations are more likely to be found in health centres and outpatient departments than in churches.

Doctors, too, when they practise pacifying medicine, are using the NHS for the wrong reasons. Naurally they prefer to keep their patients happy. Furthermore, there is a financial incentive to satisfy patient expectations: general practitioners lose a capitation fee if a disgruntled patient leaves their list. When explanation or counselling fails to satisfy a patient, the process of pacification can take over, often against a doctor's instincts, sapping his morale. The result is inessential prescribing, investigations and referral, which are of doubtful benefit to patients. Here we find, for example, the origins of the problem of overprescribing. A similar situation in hospitals, where, once a patient is referred, a full 'work up' — X-rays, blood tests and so on is virtually automatic; again clinical instinct may be by-passed and resources used inefficiently. The consultant's duty is hence discharged and the general practitioner will continue to refer.

What then are the limits of medicine? We should help the public to understand that some illness is self-limiting and some must be endured, that sometimes things improve when discussed with a non-medical person, that modern medicine is not miraculous and that happiness is not prescribable. The NHS cannot be a surrogate chaplain, neighbour or relation to everyone. If, in response to public demand, it continues to try and accommodate such roles, resources will continue to be diverted from patients with pressing medical needs.

No one should be dissuaded from seeking a medical opinion — accessibility to the NHS is crucial. But no doctor should shrink, for any reason, from relying on medical judgement (rather than a medical ruse) and delivering it. Any resulting disgruntlement by patients is likely eventually to prove educative and beneficial to patients and to the NHS. Unless the nettle of reality is grasped by laymen and professionals alike, there is a danger that to fall sick, to be seen immediately, and to be cared for appropriately — regardless of financial status — will become a thing of the past.

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