continue to have the right and opportunity to make a subsequent attempt at suicide.

We do not suggest that any method of interpreting principles that may be relevant in a volunteer based organisation would be transferable to the clinical domain, but we believe that when in doubt we should err on the side of life. Each situation will be different and will need careful and sensitive assessment (in so far as time and the circumstances permit). Nobody, however, can escape from the fact that death is for ever.

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1 Warsop A. Preventing suicide. *BMJ* 1994;309:1304. (12 November.)

Generic inhalers for asthma

Patients titrate dose against response

EDITOR,—In West Sussex prescribing of inhaled drugs for asthma has changed dramatically during the past four years. Between 1992-3 and 1993-4 alone, prescriptions for corticosteroids, measured in defined daily doses, rose by 31%, while those for bronchodilators fell by 18%. The ratio of defined daily doses of corticosteroids to bronchodilators rose from 0·44 to 0·70. This increase was achieved as a result of a determined effort and superb teamwork by every practice in the county but would not have been possible if changes to generic preparations had not been implemented at the same time.

The proportion of bronchodilators prescribed generically increased from 13·1% in October 1992 to 30% in September 1994 and that of corticosteroids from 4·5% to 24·2% in the same period. No problems resulting from these changes have been reported. It would be surprising if problems were reported because in the treatment of asthma the patient is taught to titrate the dose against his or her own response so minor differences in bioequivalence, if they exist, would be unimportant. The complaint by Mike Pearson and colleagues about the changes to generic inhalers for asthma[1] is particularly puzzling as it is well known that because of the reciprocal arrangements between the manufacturing companies many inhalers prescribed and dispensed with the brand name have in fact been produced by a manufacturer of generic inhalers.

It is essential that doctors prescribe the least expensive effective preparation available if resources are to be redistributed to maximise the benefit to patients.

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1 Pearson M, Lewis R, Watson J, Ayres J, Ibbotson G, Ryan D, *et al.* Generic inhalers for asthma. *BMJ* 1994;309:1440. (26 November.)

Money saved could be spent on patient education

EDITOR,—Mike Pearson and colleagues question the campaign to promote generic prescribing of inhalers for asthma.[1] I wish to draw attention to the cost implications of the continued use of branded products in Lancashire, where 1·4 million people are served by 284 practices.

The table shows the number of beclomethasone 50, 100, 200, and 250 μg inhalers and salbutamol 100 μg inhalers prescribed in Lancashire in the six months to September 1994. Altogether 53% of prescriptions for salbutamol inhalers were for branded products. A shift to 100% generic prescribing would have produced a saving of £102 501 on spending of £353 085. Altogether 76% of prescriptions for beclomethasone inhalers were for branded products, representing a potential saving of £132 050 on spending of £983 323.

Number and cost of prescriptions for salbutamol and beclomethasone inhalers and potential savings in six months to September 1994, Lancashire Family Health Services Authority

	No	Cost (£)
Salbutamol inhalers 100 μg		
Branded	99 649	227 530
Generic	89 949	125 555
Both	189 598	353 085
Potential saving		102 501
Beclomethasone inhalers 50, 100, 200, and 250 μg		
Branded	56 192	806 291
Generic	18 163	177 032
Both	74 355	983 323
Potential saving		132 050

Overspends on prescribing by general practitioners are to be paid for from local health authority budgets. Commissioners of care must therefore consider whether such extra costs can be justified by demonstrable clinical benefit. I know of no evidence that practices that use generic products provide less effective care for patients with asthma than those that use branded products. Compliance with the totality of effective care in asthma[2] is likely to be enhanced more by spending money on patient educators than on expensive delivery systems.

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1 Pearson M, Watson J, Ayres J, Ibbotson G, Ryan D, Flynn D, *et al.* Generic inhalers for asthma. *BMJ* 1994;309:1440. (26 November.)
2 Woodhead M, ed. Guidelines on the management of asthma. *Thorax* 1993;48(suppl):S1-24.

*Part of the author's responsibility is to advise on prescribing and encourage the use of generic medicines.

Report on Australian surgeons

EDITOR,—Simon Chapman's glowing account of the Baume inquiry into Australia's surgical workforce is tinged with his political views.[1] Professor Baume's central conclusion—that the cause of surgical waiting lists in Australia is a shortage of surgeons, which in turn is due to excessive control over surgical training by the Royal Australasian College of Surgeons—has been rejected not only by the college but also by the Australian Medical Association and the specialist surgical societies. His suggestion that, if numbers of surgeons cannot be increased rapidly, incompletely trained people should be allowed to substitute for surgeons is widely regarded as being silly.

The Baume report has been criticised not only for inaccuracies (for example, overestimating the population of Australia in 2001 by three million) but also because it ignores facts, preferring instead views based on Professor Baume's "suspicion" or anonymous submissions by disgruntled groups or individuals. Surgeons presented Professor Baume with evidence that cutbacks in public hospitals related to the budget were the cause of long waiting lists and indicated that, if they were allowed to work to full capacity, their waiting lists would disappear rapidly. This evidence was largely ignored in the conclusions of the report.

Professor Baume's conclusion that hospital bottlenecks in Australia are due to a shortage of surgeons, who, he said, are relucant to work in public hospitals, is an untruth that has left surgeons gasping. In general surgery there are virtually no unfilled consultant vacancies in urban Australia, where waiting lists are longest. When such a vacancy was advertised recently at Westmead Hospital (a teaching hospital of the university in which Chapman works) almost 100 people applied.

Chapman says that Professor Baume drew attention to the "fantastic incomes" of surgeons. This phrase does not appear in the report, and the fantasy is therefore Chapman's. Fantasy, however, is an appropriate word, as Professor Baume pointed out that the quoted figures for doctors' incomes may be inaccurate and that the amounts represent gross income, from which practice expenses (ranging from 50% to 90%) need to be deducted. Australian surgeons' net incomes are, in fact, modest compared with those of other professional groups.

Chapman, a colleague of Professor Baume, describes him as "a creative egg cracker in medicopolitical cake baking." This assessment of Professor Baume is not shared universally by Australian doctors. The late Professor Fred Hollows, who encountered Professor Baume when the latter was minister for aboriginal affairs, was extremely critical of him,[2] and many Australian surgeons support his view.

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1 Chapman S. Australian surgeons savaged by cutting report. *BMJ* 1994;309:1254. (12 November.)
2 Hollows F, Corris P. *Fred Hollows—an autobiography.* Kerr: Sydney, 1992.

Treatment of low back pain

EDITOR,—Kwame McKenzie's news item about the Clinical Standards Advisory Group's report on the treatment of low back pain omits to state that general practitioners should have direct access to osteopaths as well as to chiropractors and physiotherapists.[1] Osteopaths should be part of the forthcoming and much needed "revolution."

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1 McKenzie K. Back treatment needs revolution, says report. *BMJ* 1994;309:1602. (17 December.)

Primary care and general practice

EDITOR,—In their editorial on the primary health care team Pauline Pearson and Kevin Jones fail to ask one fundamental question: does "primary care" exist?[1] Increasingly, primary care is used as a synonym for general practice. For an example of this, one need look no further than Kathryn L Evans's review of sinusitis, in which she writes that "most uncomplicated acute sinusitis is managed in Britain in primary care."[2] This is one of hundreds of examples that appear in journals every week and are heard in common speech. This use is misleading.

Many people in primary care professions have no direct or regular links with general practice and yet offer community based health interventions with open access. These people include opticians, dentists, chiropodists, shop pharmacists, osteopaths, school nurses, and child guidance professionals. As Pearson and Jones point out, other primary care workers who do work with general practitioners, such as district nurses and health

visitors, may have only tenuous links with them. Other attached professionals, such as social workers, mental health nurses, and clinical psychologists, also have only sporadic contact in most cases.

The problem is not only semantic. The phrase "primary care" creates an illusion of managed, coherent, multidisciplinary institutions analogous to those in secondary care. This illusion allows the government, managers, and hospital consultants to believe that primary care (namely, general practice) is ready to meet the vast demands of decentralisation of the NHS as outpatient clinics shrink and admissions to hospital become shorter.

In reality, there are simply two clinical professions that work in day to day collaboration in most general practices. The people in these professions are doctors and practice nurses. The only other members of the general practice team are practice managers, secretaries, receptionists, caretakers, and cleaners. General practice is, in effect, a cottage industry. The idea that you can decant one of the world's largest industrial organisations—NHS hospital care—into something called primary care is largely a delusion.

The truth is that most of the primary care sector does not do general practice and that general practice cannot remotely meet the demands being asked of primary care. I suggest that when we mean general practice we should say general practice. Like Pearson and Jones, we should be realistic about what it is and is not.

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1 Pearson P, Jones K. The primary health care non-team? *BMJ* 1994;**309**:1387-8. (26 November.)
2 Evans KL. Diagnosis and management of sinusitis. *BMJ* 1994; **309**:1415-22.

Electronic health records

EDITOR,—I fear that Dipak Kalra seems to have missed what is going on in computing in general practice in Britain while concentrating on other European countries.

Kalra says that "EDIFACT will soon be used in primary care to communicate fee claims." In fact, links between general practices and family health services authorities for registration have functioned for at least two years, and last September my practice completed the first full year of using the system for item of service claims and reimbursement.

Only three software systems for general practice passed initial conformance testing for item of service links. Our practice runs ESUG (Exeter Software Users Group) and in the first year of linkage had 3856 item of service claims. This system should save our family health services authority in Cleveland an extraordinary amount of time. The authority estimates that it takes an average of four minutes to process a paper claim. We should have saved the authority about 280 person hours in one year. Across the country the savings would be enormous.

Kalra identifies the need for an agreed patient database for this kind of project to work. There were some 16 000 mismatches of data between our records and those of the family health services authority. These were mostly incorrect spaces or mismatches of punctuation. While we wait for European agreements local agreements may be reached, and computer programs can now generate agreed databases.

The full benefits to general practice of electronic linkage will not be realised until the Department of Health agrees to abandon paper claim forms and signatures and accepts that computer claims (with proper audit trails and good software) are less open to fraud than claims on paper. The main beneficiary of links so far is the family health services authority. If it does not fund links fully it will lose that benefit.

It seems extraordinary that huge European projects with vast funding are taking place when the project linking general practices with family health services authorities, which is working well, will result in potentially large financial savings, and has major potential for leading to improvements in demographic data and planning, is not being backed to the hilt.

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1 Kalra D. Electronic health records: the European scene. *BMJ* 1994;**309**:1358-61. (19 November.)

Problems of overseas adoption

EDITOR,—Rupert Robin proposes that general practitioners should advise infertile couples that adoption is a suitable "treatment."[1] He also suggests that adoption in such cases will save NHS resources and at the same time help the deserving orphans of Third World countries. If only life were this simple and solutions to complex problems so easy to find. Adoption is not simple, therapeutic, or cost effective. It is a totally child centred process in which decisions are made only in the best interests of a particular child. When being assessed as potential adopters, couples have no automatic rights to adopt and all that matters is their ability to parent and meet the needs of a very disadvantaged child. When this process is properly done it is far from cost effective. The average costs of a full assessment vary between £6000 and £10 000.

Adoption is not for everyone. Most adopted children in this country come from backgrounds of abuse and neglect, need to be placed in sibling groups, or are of mixed race. They require very special adopters to meet their needs and heal their emotional damage. It is to avoid these difficult children that couples often resort to adopting babies from other countries. These babies often have birth families who are alive and who in better circumstances would be capable of looking after them. The babies may have undiagnosed medical and developmental needs. They will grow up to be teenagers who will almost certainly ask hard questions about their birth families, their origins and culture, and why they have to travel thousands of miles to find the answers. I wonder how they will view this simple solution.

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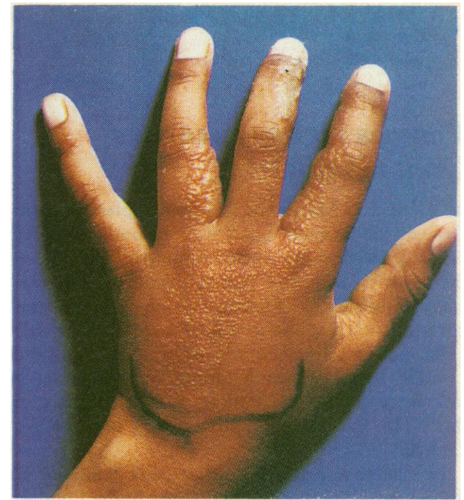
1 Robin R. Overseas adoption. *BMJ* 1994;**309**:1516. (3 December.)

Allergy to colophony

EDITOR,—A D Burden and W N Morley report a case of allergy to colophony. We recently treated a 9 year old boy who presented with inflammation around a periungual wart on the left middle finger after two days' treatment with salicylic acid (Cuplex). The treatment was stopped and the finger dressed with a tubular bandage taped to the hand. Two days later the child was admitted to a surgical ward with a swollen left hand and blistering of the skin that was in contact with adhesive tape; cellulitis was diagnosed (figure). Within hours of his admission itchy blisters developed under adhesive tape around an intravenous cannula. Subsequent patch testing confirmed contact allergy to colophony, a constituent of both the wart treatment and the adhesive tape. The swelling and blisters resolved rapidly with treatment with a potent topical corticosteroid.



Allergic reaction to colophony

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1 Burden AD, Morley WN. Minerva. *BMJ* 1995;**310**:202. (21 January.)

Leeches

EDITOR,—Anders Baerheim and Hogne Sandvik observed the effect of ale, garlic, and soured cream on the appetite of leeches.[1] The three leeches that I met in Tasmania recently were not adversely affected by gorging on a paronychia of the thumb filled with pus. During a hiking holiday through the Cradle Mountain area of Tasmania leeches were applied to my colleague's paronychia. They gave instant relief from pain and reduced the swelling dramatically. The leeches' production of local anaesthesia was such that within seconds the throbbing had disappeared and minutes later the thumb had returned to normal size, so that surgery was unnecessary. The thread-like leeches became the size, shape, and colour of blue grapes. They were detached from the thumb by use of saline solution and were returned to the wilderness.

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1 Baerheim A, Sandvik H. Effect of ale, garlic, and soured cream on the appetite of leeches. *BMJ* 1994;**309**:1689. (24-31 December.)

Corrections

Biological washing powders as allergens

A typesetting error occurred in this letter by Michael Flindt (21 January, p 195). The second half of the first sentence of the final paragraph should have read: "it is particularly unfortunate when patients are symptomatically treated for asthma while they continue unknowingly [not knowingly, as printed] to be exposed to a specific allergen."

Interpretation of electrocardiograms by doctors

Owing to an editorial error the authors' address was omitted from this letter by P A Woodmansey and colleagues (18 February, p 468). Their address is the department of cardiology, Royal Hallamshire Hospital, Sheffield S10 2JF.