general practice in the United Kingdom. Called, imaginatively, GP-UK, the list is run by collaboration between the Sowerby Unit for Primary Care Informatics at Newcastle University and the Primary Health Care Specialist Group of the British Computer Society. GP-UK deals with topics such as clinical research and medical informatics, with specific reference to British general practice. Within its first six months it has over 150 members. Views from outside the United Kingdom are also welcome, and, indeed, the list includes members from Europe, Australia, and the United States. To join simply send an email message containing the following command to mailbase@mailbase.ac.uk:

join gp-uk <firstname> <surname>
stop

A few words of caution may be appropriate amid the euphoria, however. As interest and traffic increases, discussion lists are in danger of becoming swamped: the bulk of information becomes too daunting for regular readers, who then cease to contribute. In response, list owners may become in reality editors, producing a regular digest of important contributions, or the list may have to be divided into daughter lists covering specialist subjects.

This all requires human and financial resources. We are grateful to Mailbase for its support, but this can be maintained only for as long as the list is perceived to be academic rather than clinical. As interest broadens and deepens additional resources will be required.

IAN PURVES
Director

Sowerby Unit for Primary Care Informatics,
Department of Primary Health Care,
Medical School, University of Newcastle,
Newcastle upon Tyne NE24HH
email: Ian.Purves@newcastle.ac.uk

MICHAEL BAINBRIDGE
General practitioner

Applied Intellect,
Castle Donington,
Derby DE7 2NS
email: mikebain@phcsg.demon.co.uk

IAN TRIMBLE
General practitioner

Sherwood Health Centre,
Nottingham NG5 4AD
email: trims@sherwood.demon.co.uk

1 LaPorte RE. Global public health and the information superhighway. *BMJ* 1994;308:1651-2.
2 Coiera E. Recent advances: medical informatics. *BMJ* 1995;310: 1381-7. (27 May.)
3 Delamothe T. *BMJ* on the Internet. *BMJ* 1995;310:1343-4. (27 May.)

Helping health services in the developing world

EDITOR,—Michael Harper outlines an excellent example of a mutually beneficial relationship between general practice in Britain and a community health scheme in rural India.[1] We too are engaged in giving help to the health services in part of the developing world. Current development theory equates sustainable development with economic self sufficiency. Our experience, like Harper's, is that it is more a question of "holistic interchange." With the meagre resources available to the health service in a country such as Nepal, insisting on economic self sufficiency is equivalent to doing nothing (or, at least, very little) while Rome burns. There is no realistic prospect of adequate government funding of the health service in this part of the world within the next several decades.

Western health centres should not allow concern about continuing financial burdens to prevent them from exploring the rich experiences, both personal and professional, available through contact with a southern health programme. Nor should general practitioners balk at helping overseas district hospitals, which are often of equivalent scope to group practices, with similar problems and novel solutions—we are all engaged in primary health care.[2,3]

Would that there was some kind of exchange for interested parties to make contact, as Whiteladies Healthshare Project has done. Social workers with their initiative are, alas, too rare. We would certainly welcome any interest in our work in the district general hospitals of this remote area of Nepal.

CHARLIE COLLINS
Clinical specialist

ROD MACRORIE
General physician

Hospital Assistance Project,
International Nepal Project,
PO Box 5, Pokhara,
Nepal

1 Harper M. Healthshare: Clifton to Pachod. *BMJ* 1995;310:947. (8 April.)
2 Hospitals and health for all. *WHO Tech Rep Ser* 1987;No 744.
3 Ebrahim GJ, Ranken JP, eds. *Primary health care—reorienting organizational support.* London: Macmillan, 1988.

Effects of drinking green tea

EDITOR,—The *BMJ* is regarded as one of the most important journals for original medical research in the United Kingdom and often acts as a source of information for the lay press. The fact that K Imai and K Nakachi's paper was accepted for publication reflects badly on the journal's peer review system.[1] The paper states that "green tea may act protectively against cardiovascular diseases and disorders of the liver." This is based on the observation that drinking more than 10 cups of green tea a day changes the mean alanine amino transferase concentration to 19·9 from 24·1 U/l in patients drinking less than three cups a day.

I would be interested in the evidence that an alanine amino transferase concentration of 19·9 U/l indicates a reduced risk of liver disease compared with a concentration of 24·1 U/l, both of which lie well within the normal range for this variable. We are also told that the cholesterol concentration was 4·58 mmol/l in the high consumers compared with 4·85 mmol/l in the low consumers and that this again represents a significant reduction in the cardiovascular risks. While this lowering may be statistically significant, I defy the *BMJ* to show evidence that it is of any clinical significance.

The *BMJ* has a responsibility to publish only well researched studies with valid conclusions. This paper shows that it is failing in that duty.

J ALAN ROBERTS
Consultant physician in general and thoracic medicine

Department of Medicine,
Royal Hampshire County Hospital,
Winchester SO22 5DG

1 Imai K, Nakachi K. Cross sectional study of effects of drinking green tea on cardiovascular and liver diseases. *BMJ* 1995;310: 693-6. (18 March.)

CD4 cell counts used as surrogate test for HIV infection

EDITOR,—The Haematological Malignancy Diagnostic Service in Leeds provides a diagnostic service for patients with suspected haematological malignancy in Yorkshire. Recently, we have become aware of increasing numbers of requests for CD4 cell counts. On further investigation we have found that in most instances these investigations have been requested as a surrogate for serological testing for HIV infection.

Knowlege of the CD4 cell count is useful only in monitoring the progression of disease in patients who are known to be infected with HIV. The count may be normal or decreased in HIV infection and in a wide range of other infective or immunological conditions. If HIV infection is suspected the CD4 cell count is of no value in either confirming or excluding the diagnosis.

Explicit informed consent should be sought before an HIV test is performed, and facilities for counselling are made available to the patient should the result be positive. Some clinicians may consider that a request for a CD4 cell count circumvents the need for consent and counselling, especially in those in whom they have only a low index of suspicion of HIV infection. When they fail to request the definitive test such a suspicion may persist and be conveyed to other health professionals in contact with the patient. This may ultimately be detrimental to the delivery of effective health care to the patient. The confidentiality that patients suspected of having HIV infection have a right to expect may be compromised.

It has also been our experience that requests of this type rarely contain accurate clinical information, and samples are seldom labelled as a potential infection hazard. This constitutes a risk to a wide range of staff, including phlebotomists, medical laboratory assistants, and technologists.

We recommend that laboratory staff should always verify the reason why a clinician has requested a CD4 cell count. Samples sent from a surrogate HIV test should be discarded in the interests of good patient care and laboratory safety.

A S JACK
Consultant

S RICHARDS
Senior clinical scientist

Haematological Malignancy Diagnostic Service,
Institute of Pathology,
Leeds General Infirmary,
Leeds LS1 3EX

General practice's last stand

EDITOR,—As the author of the discussion document from the BMA's General Medical Services Committee on core general medical services and the classification of activity by general practitioners,[1] I wish to respond to D P Kernick's attack on the document as "a milestone in our professional decline."[2] Kernick, who targets not only me but also the president of the BMA and the chairman of its council, portrays the discussion paper as futile, misconceived, anachronistic, and the product of a bunker mentality. While Kernick purports to have positive ideas about the future of general practice, the article seems to be singularly negative and lacking in faith.

The author's case seems to be that doctors should now no longer be paternalistic but should work in partnership with their patients; that the quality of care should be improved; and that general practitioners will increasingly have to develop business and managerial skills and a role in assessing need and in planning, managing, and delivering services accordingly. How Kernick conceives that I, the GMSC, or the discussion document espouses contrary views I cannot imagine.

Kernick's contention that "virtually all change has been imposed from without and almost universally characterised by professional antagonism" rewrites history with a vengeance. I would contend that the three greatest developments in general practice since the inception of the NHS have been the introduction of the Cameron contract in 1966, of mandatory vocational training in 1979, and of commissioning of care in 1991. The first two of these developments were the direct result of pressure from general practitioners, in which the GMSC took a leading role. Only the most recent development met with opposition from most general practitioners before its introduction, and, whatever the different attitudes to fundholding that remain, the commissioning role that is available to all practitioners as a result of the