Although there is some overlap between the two sets of proposals, they have very different implications. It is therefore essential that we respond to them separately. It is perfectly logical—and probably politically more effective—to oppose one but not the other.

The white paper is about fundamental changes to the NHS as a whole. It has no clear commitment to more money for NHS services—the only commitment on financing the NHS is that it will continue to be "financed *mainly* out of general taxation" (my italics). Although its stated objectives, such as more audit, are welcome, the core of its proposals relate to the imposition of an untested market oriented system on the NHS. Anyone who believes that such proposals are misconceived and likely to damage the interests of patients has every reason—a duty, even—to oppose the white paper. There is nothing blind about such opposition.

Most of the contract proposals are about the way general practitioners are paid and will affect patients much less directly. Some of them certainly need to be withdrawn or modified, including the unrealistic nationwide targets for immunisation and cervical screening and the obligation to carry out health promotion activities for which there is no clear evidence of effectiveness. However, let us demonstrate how reasonable we are by negotiating on the contract while opposing the white paper.

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1 Hewish P. NHS review: no hope in blind opposition. *Br Med J* 1989;**298**:889-90. (1 April.)

SIR,—In view of the enormous increase in the information that we expect to receive from the information revolution proposed in the white paper, I though I ought to let you know of the current state of affairs as regards information for plastic surgery.

A patient recently asked me where he could obtain the quickest plastic surgical appointment. My secretary rang the Department of Health, which told us that it did not have the information. My patient wrote to the department, which suggested that he should write to the various regional health authorities in England to give him a list.

I asked him to do so; the results are presented in the table. The information took my secretary, me, and my patient about three months to accumulate. I am now fearful that in future we will have to write to each individual region and hospital to find out not only their waiting lists but also the particular costs of each treatment that we require for our patients.

Waiting lists for plastic surgery in regional and district health authorities in England

	Waiting time (weeks*)
South West Thames:	
Queen Mary's Hospital } Roehampton	2-5
St George's Hospital } Roehampton	4
East Anglian†	
Mersey:	
Outpatient	21
Inpatient	69
West Midlands†:	
Dudley	6-24
North Warwickshire	9-10
Coventry and Warwickshire Hospital	5-20
North East Thames	> 16 months
South East Thames:	
King's College Hospital	0-33
Surgery	20
Guy's Hospital	0-5
Surgery	107
Salisbury	12
Surgery	2 years
North West Thames	27·5 months

*Unless stated otherwise.
†Doctor asked to write for information.

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SIR,—Like Dr A Morgan and others[1] we are general practitioners in London who are enthusiasts for health promotion. We regard their enthusiasm for the new contract for general practitioners, however, as both naive and ill thought out.

The central drive of the contract—that is, a sharp increase in the element deriving from capitation—is thoroughly retrograde. It will force list size up and consultation time down. Single-handed colleagues will be driven to extensive non-NHS work to maintain their income, and incoming vacancies will become still rarer. The target figures for vaccination and cervical cytology are simply unobtainable in inner cities given the problems of list inflation, patient turnover, and ethnic minorities. Indeed, it seems to us quite extraordinary that anyone with a knowledge of modern urban practice would ever draft such proposals. The contract itself is wedded to the white paper's philosophy of competitive marketplace care, which is an inappropriate and inefficient method of health care provision. Inner city doctors like ourselves are likely to be especially penalised by the white paper's plans as hospitals opting out will probably leap frog over us and our patients to do business with megapractices holding budgets in the affluent south east. The community health services, which we find so valuable in health promotion, would be marginalised by the white paper's proposals.

The contract for general practitioners needs to be developed, and a few of the features in the proposed draft, such as an allowance for social deprivation, are appropriate.[2] But the philosophies of the present draft, its effect on general practitioners' income and terms of service, and the arrogant manner in which it is being imposed are unacceptable.

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1 Morgan A, Bower P, Barnard S, Bird C. NHS review. *Br Med J* 1989;**298**:747. (18 March.)
2 Widgery DJ. *The national health.* London: Hogarth, 1988:78-81.

Enhanced transmission of HIV to women in South Africa

SIR,—The editorial by Professor D C G Skegg[1] focused on the transmission dynamics of HIV infection and rightly emphasised the importance of sexually transmitted diseases and genital ulceration in enhancing virus transmission and their role in accounting for the varying rates of transmission found in different heterosexual risk groups.

In the sexually transmitted diseases clinic attached to this hospital about 6000 black patients with genital ulceration are seen each year. A recent survey of 100 men and 100 women with genital ulceration showed the men to have had more sexual partners over the three month period before their attendance at the clinic, the men admitting to a total of 190 partners (range 0-7) and the women to 114 (range 0-3). Recurrent attenders at the clinic and patients with genital ulceration were offered HIV antibody testing with consent from July 1988 to January 1989. The overall antibody prevalence was 2·5% (62/2461), 2·1% of men (32/1524) and 3·2% of women (30/937) being seropositive, giving a ratio of men to women of 1:1·5.

Sexually active men and women are generally affected by HIV infection in about equal proportions in sub-Saharan Africa,[2] although an excess of female patients with AIDS was found in Ghana in 1986 after repatriation of prostitutes from neighbouring countries. Our study, however, shows a higher prevalence of HIV antibody in women even though no prostitutes were identified. This may be accounted for by the higher transmission rate of the virus from men to women.

Prostitutes and patients with genital ulceration are recognised risk groups for both infection with and transmission of HIV, and our studies suggest that, just as female prostitutes represent a focal group for spread of HIV infection into the male community, so may HIV positive men with genital ulceration and many sexual partners represent a key group for spread into the female population in our area.

Health education, counselling, and providing condoms for patients with genital ulceration should now be regarded as a priority.

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1 Skegg DCG. Heterosexually acquired HIV infection. *Br Med J* 1989;**298**:401-2.
2 Anonymous. AIDS in sub-Saharan Africa. [Editorial.] *Lancet* 1988;i:1260-1.
3 Neequaye AR, Neequaye J, Mingle JA, Adjei DO. Preponderance of females with AIDS in Ghana. *Lancet* 1986;ii:978.

Iron deficiency in adolescents

SIR,—Iron deficiency in children has been the subject of much recent interest following reports of impaired intellect and behaviour in children with iron deficiency reversed by treatment with iron,[1] and Dr Paul Armstrong has now found a high prevalence of iron depletion among Irish adolescents.[2] Recent British studies have shown high levels of iron deficiency in young children in hospital or areas with a large proportion of Asian families.[3 4] In a study aimed at defining the prevalence of iron deficiency in white children and exploring the effects of economic deprivation we found unexpected results.

We studied children aged 9-15 months attending baby clinics in two areas of Newcastle, one an affluent suburb, the other a deprived inner city area. Capillary blood (0·25 ml) was collected from the great toe into a bottle containing edetic acid, and haematological variables were measured by Coulter counter. A blood film was examined and haemoglobin electrophoresis performed. Lower limits of normal for haemoglobin, mean cell volume, and mean cell haemoglobin were defined as the third centile,[5 6] and iron deficiency was defined as subnormal mean cell volume or mean cell haemoglobin with an otherwise normal blood film and electrophoresis.

Children from the two areas showed the same age distribution, but the "deprived" children were significantly more likely to have had low birth weight, a hospital admission, or an unemployed parent. There was no significant difference in the haematological findings between the two areas (table). The overall prevalence of anaemia (13·5%) was similar to that found in other studies,[3 4] but cell variables suggestive of iron deficiency were seen in many fewer cases (3·5% overall). The correlation between iron deficiency and anaemia was poor; of the five children with subnormal mean cell volume and mean cell haemoglobin, three had a normal haemoglobin, and of the 19 with low haemoglobin only two had mean cell volumes or haemoglobin values suggestive of iron deficiency. Direct measures of iron stores were not available, but seven of the 19 children with apparent anaemia had mean cell values above the median, making iron

Haematological findings in children from two areas

	Deprived (n=70)	Affluent (n=71)	p Value
Mean (SD) haemoglobin (g/l)	119 (12)	122 (12)	0·206*
Mean (SD) cell volume (fl)	77·1 (4·4)	77·6 (3·3)	0·493*
Mean (SD) cell haemoglobin (pg)	26·4 (1·8)	26·8 (1·6)	0·248*
No (%) anaemic (Hb < 11 g/l)	11 (16)	8 (11%)	NS†
No (%) iron deficient‡	5 (7)	0	NS†

*t test.
†χ^2 test.
‡Mean cell volume <70 fl or mean cell haemoglobin <24 pg.

deficiency in these children highly unlikely. Haemoglobin values in individuals show a high degree of variability, and capillary samples may introduce further error.[7] Mean cell volumes and haemoglobin values, however, are much more consistent. While there are many causes of anaemia, in the absence of haemoglobinopathy lowered mean cell volume and mean cell haemoglobin strongly suggest iron deficiency.

Future studies should ideally measure ferritin concentrations in venous blood and then do a therapeutic trial of iron. In practice such a study in well babies would be a major undertaking. In the mean time our study suggests that iron deficiency may not be a major problem in white toddlers and that capillary haemoglobin estimations are a poor way of measuring anaemia or iron deficiency in the community. The latter point is particularly relevant after the recent Hall report on child health surveillance, which, while not recommending screening for iron deficiency, does suggest that further research is needed and that haemoglobin estimations may be a useful "screening" test. We would disagree.

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1 Oski FA. Iron deficiency—facts and fallacies. *Paediatr Clin North Am* 1985;32:493-7.
2 Armstrong PL. Iron deficiency in adolescents. *Br Med J* 1989; **298**:499. (25 February.)
3 Aukett MA, Parks YA, Scott PH, Wharton BA. Treatment with iron increases weight gain and psychomotor development. *Arch Dis Child* 1986;**61**:849-57.
4 Ehrhardt P. Iron deficiency in young Bradford children from different ethnic groups. *Br Med J* 1986;**292**:90-3.
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Coping with disaster

SIR,—One week after two trains travelling to London collided close to Purley station we read the report from the staff of the casualty departments who dealt with the M1 disaster.[1]

After passing through a stage of euphoria at having coped with most of the casualties from the railway crash we have started our more sobering audit of the incident. It is premature to draw conclusions, but our initial impression is that many of the lessons to be learnt are identical with those included in the report of the M1 disaster. These are problems of communication, terminology, documentation, and procedure. It seems that such difficulties are universal and there is an urgent need for the establishment of a national protocol.

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1 Staff of the accident and emergency departments of Derbyshire Royal Infirmary, Leicester Royal Infirmary, and Queen's Medical Centre, Nottingham. Coping with the early stages of the M1 disaster: at the scene and on arrival at hospital. *Br Med J* 1989;**298**:651-4. (11 March.)

System review

SIR,—Dr B I Hoffbrand is concerned that medical students are still taught to include a systems review in their history taking, when it has "a high degree of observer variability" and may "seriously interfere with the diagnostic process."[1] He does not consider one of its substantial advantages in medical training.

Somehow medical students have to find out the vast range of replies that patients without disease of a particular body system may give to questions about that system as well as what patients with disease may say. They have to learn the overlap of the results from the two groups of patients and develop a notion of the variability among patients to reduce their own observer variability in obtaining useful information.

Given the present numbers of hospital inpatients and clinical students, this learning phase is shortened by asking patients seemingly irrelevant questions, just as students obtain valuable experience of the great range of physical signs shown by healthy people by examining the nervous system in patients recovering from a pulmonary embolus and the chest in those with disease of the motor system.

Of course, this thorough explanatory phase should evolve into one of parsimonious decisiveness, but the question of how trainees become independent practitioners is a different one not unique to medicine and not dealt with by Dr Hoffbrand.

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1 Hoffbrand B. Away with the system review: a plea for parsimony. *Br Med J* 1989;**298**:817-9. (25 March.)

Popper and Lakatos's syndrome

SIR,—John Gabbay's article made the following statement: "Stephen Black's work published in the *Lancet* of 1954 . . . claimed to have reversed positive Heaf test results by hypnotic suggestion, which, if true, should have been enough to blow immunology sky high. . . ."[1]

The work in question appeared not in the *Lancet* of 1954 but in the *British Medical Journal* of 1963[2]; Mantoux not Heaf tests were used; and no claim was made to have "reversed" the results. As these misquotations do great disservice to the memory of three distinguished medical scientists, none of whom are now alive, I hope that you will allow me to put the record straight.

The research in question was done at the National Institute for Medical Research by Stephen Black, John Humphrey, and Janet Niven, the last two being, respectively, directors of the divisions of immunology and cytology. The original account, later supplemented in a book,[3] contains a description of an experiment that formed part of a series of studies on modifying allergic responses by hypnosis.

In brief, tuberculin positive volunteers responsive to hypnosis were given a Mantoux test with doses of tuberculin individually titrated to give standard areas of induration one centimetre in diameter. Control areas were injected with saline, and a Mantoux negative control subject given a high dose of tuberculin was also included. The tests were repeated after 12 daily sessions of hypnotic suggestion that no lesion would develop. Full thickness skin biopsy specimens were taken from all lesions and control areas under general anaesthesia and repaired by a plastic surgeon. The specimens were all serially sectioned and stained by various techniques.

The conclusions, backed up by photomicrographs, were clear. Erythema, induration, and exudation of fluid into the tissues were completely inhibited, or nearly so, by hypnotic suggestion, but "the cellular infiltration characteristic of the delayed type response was essentially unchanged." In other words, the fundamental immunological reaction was unaffected by suggestion whereas the vascular component was abrogated. In view of the well known skin reactions to psychological stimuli this finding is not surprising; in no way did it "blow immunology sky high."

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2 Black S, Humphrey JH, Niven, Janet SF. Inhibition of Mantoux reaction by direct suggestion under hypnosis. *Br Med J* 1963;i:1649-52.
3 Black S. *Mind and body.* London: Kimber, 1969:230-43.

Finding a doctor: too much of a lottery

SIR,—I disagree totally with Dr Irvine Loudon's suggestion of an interview with a new general practitioner before joining his or her list.[1] There is only one possible reason for this exercise and that is so that either the doctor or the patient can then decide not to have medical dealings with the other. If the interview is satisfactory on both sides then it is completely unnecessary.

I believe that it is my medical duty to accept patients on to my list if they live in my practice area, regardless of age, sex, colour, creed, political persuasion, medical and psychiatric history, and—dare I say it—possible demands on the National Health Service budget. On the general practitioner's side a pre-acceptance interview can be an exercise only in instant discrimination. On the other hand, if patients find my personality and medical approach inappropriate for their needs—however long they have been registered with me—then of course they must exercise their right to seek medical attention either from my partners or from another practice as easily as possible.

In the 12 months from July 1987 our four partner practice in suburban Birmingham had over 27 000 face to face consultations with a list of 7000 patients. Over the same period we accepted 500 new patients, which makes up a rather lower patient turnover figure compared with that of our inner city colleagues. I do not think that it is fair on our registered patients to offer two appointments (in the surgery or in the home if the potential patient is housebound) per working day to people who have not even registered with us—or perhaps it should be eight appointments so that the potential patients can interview all four of us to see whom they prefer? And should we be available for interviews for all the patients registered with