cribe exercise offer a potential strategy to help patients change their lifestyle. The general practitioner identifies a sedentary patient with a disease that would benefit from exercise and writes a prescription for the patient to attend the scheme. This ensures that over 90% of those receiving the prescription present to the leisure centre to start the programme. An exercise specialist makes an initial assessment of the patient, which includes a submaximal test of exercise fitness, and tailors the prescribed exercise to the patient's fitness and disease. The aim is to educate the patients about how to exercise and to understand their body's response (for example, by rating perceived exertion[3]) such that at the end of a three month programme they can more safely exercise in the manner of their choosing. They are empowered to control their health.

It is important that any such scheme is evaluated, and a database for collecting data is now established in East Sussex to examine the changes in health and any changes in prescribing that may result. East Sussex Family Health Services Authority and Health Authority have recognised the need for such evaluation, and all schemes now developing in East Sussex under the name of the Health and Leisure Organisation will have the same method of collecting data and staff training scheme (under the guidance of the University of Brighton) and will provide educational programmes for referring doctors.

I agree with Iliffe and colleagues that primary health care teams need to examine what their local scheme offers, but in response to their conclusion that "there may be many far more effective ways for [the teams] to use their resources to increase the fitness of their practice populations" I say, "tell me what and show me how."

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Fitness for older people

EDITOR,—As Archie Young and Susie Dinan state, the improvements of older people's aerobic capacity, endurance, strength, and flexibility with regular exercise are similar in percentage terms to those seen in younger people.[1] These improvements have clear advantages, allowing a more active lifestyle, and if exercise is continued they should help the person to maintain his or her independence and delay the approach of critical functional thresholds that herald immobility.

Perhaps less well recognised are some of the other improvements seen in older people after exercise training. The ventilation threshold—the point at which anaerobic metabolism begins to augment aerobic metabolism during exercise—rises as a percentage of maximum oxygen consumption with age.[2] Yet critical power—the highest sustainable workload as a percentage of maximum workload—in trained older people is similar to that in young people.[3] Healthy older people are therefore capable of prolonged submaximal "work." The dynamic responses in oxygen uptake, carbon dioxide exchange, ventilation, and heart rate at the onset of exercise slow with inactivity and aging.[4] In exercise trained older people the kinetics of these responses accelerate and approach those of younger trained people.[4] Similarly, I have shown that the kinetics of the ventilatory response to hypoxia are faster in trained than sedentary older people (unpublished MD thesis).

The approach to exercise training for older people in Britain is quite different from that which I have seen in Canada, reflecting the demands and expectations of North American practice, the greater availability of suitable facilities, and the greater interest shown by the retired population. There, in contrast with the rather informal procedure in Britain, entrants to exercise training programmes undergo a medical examination and supervised treadmill exercise to a functional maximum to identify factors of importance during exercise—for example, critical coronary artery disease. This permits the calculation of an effective and safe personal training heart rate, within the training sensitive zone, from the person's maximum heart and work rates. The use of target heart rates during exercise training in older people does not seem to be common in Britain but would be advantageous in monitoring the intensity of exercise, as a guide to increments in the intensity of training, and for safety. Which practice is thought correct or appropriate will depend on the country of practice, target intensity of exercise, and subject's risk factors.

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Initial management of suspected meningococcal infection

EDITOR,—The overall mortality and morbidity in childhood bacterial meningitis have changed little over the past three decades despite the availability of an effective range of antibiotics. Since the introduction of *Haemophilus influenzae* type b vaccine the incidence of serious haemophilus infections has fallen dramatically. The initial management of meningococcal infections has therefore become relatively more important and may even have to be modified.

The chief medical officer continues to emphasise the importance of early administration of parenteral benzylpenicillin by a general practitioner before the patient's transfer to hospital to minimise the mortality and morbidity in meningococcal infections.[1] However, the assumption that prompt antimicrobial treatment greatly improves the outcome of meningococcal infections remains controversial.[2]

The use of dexamethasone as adjunctive treatment is now accepted as routine policy in many paediatric units in Britain despite the dramatic reduction in *H influenzae* infections. Few data from published studies are available to show any benefit resulting from administration of dexamethasone in meningitis due to any organism other than haemophilus. The meningitis working party of the British Paediatric Immunology and Infectious Disease Group advocated caution in the use of adjunctive steroid treatment in children with meningococcal disease until more evidence was available.[3]

The ideal timing of the initial dose of steroids for optimal benefit is also not well understood. Several studies, however, have reported a beneficial effect when the first dose of steroid is given before antibiotics.[4] The chief medical officer's advice on early administration of benzylpenicillin by the general practitioner may therefore be inappropriate and even harmful.

In the light of these changes and the conflicting information available, can we justify the insistence on early administration of penicillin by the general practitioner and the use of adjunctive steroid treatment? These issues should be reviewed, and a set of guidelines based on clear, rational, and scientific data should be agreed nationally.

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Tuberculosis and slim disease in Africa

EDITOR,—S B Lucas and colleagues found that tuberculosis was associated with the wasting that is characteristic of so many deaths related to HIV infection in Africa.[1] They conclude that the aim should be prophylaxis or earlier diagnosis and treatment.

Preventive treatment for tuberculosis in Africa continues to excite controversy. The International Union against Tuberculosis and Lung Diseases and the World Health Organisation issued a joint statement in October 1993 which recommended "isoniazid preventive therapy for individuals with both tuberculosis and HIV infections."[2] Meanwhile, in December 1993, one of the final recommendations of the African regional meeting of the international union was that "Preventive chemotherapy of HIV seropositive individuals infected by the tuberculosis bacillus is not a cost-effective measure in programmes in Africa, and is not possible in countries with a high prevalence of tuberculosis."[3]

These positions are not contradictory: rather, they emphasise the different priorities for individual people and control programmes. Preventive treatment is likely to be effective in reducing the incidence of active tuberculosis in those infected with both HIV and *Mycobacterium tuberculosis*,[4] although the only African data have yet to be published (D Wadhaven *et al*, eighth international conference on AIDS, Amsterdam, 1992). Prevention of opportunistic infections has led to considerable improvements in life expectancy of those found to be HIV seropositive in the industrialised world: the prevention of tuberculosis could have similar benefits in Africa. Whether it will prove feasible to implement preventive treatment for more people is not clear. Data from Uganda emphasise the large number of people who have to be screened for HIV antibodies to get one person on to isoniazid (T Aisu *et al*, ninth international conference on AIDS, Berlin, 1993). Without data on how efficacious or feasible treatment is, it is clearly not possible to derive cost-benefit analyses. Simplistic calculations make it clear, however, that giving four patients treatment might be hoped to prevent one case of active disease, which would result in a saving on drug costs,[5] although this does not consider the costs of screening the four patients or investigating and caring for the one.

There is considerable ambivalence about being

tested for HIV antibodies in Africa, despite donor and government plans to implement voluntary testing centres. In Zambia, for example, international donors are funding the testing of up to 5% of the adult population of Lusaka. If preventive treatment for tuberculosis proves efficacious, it will be the first major medical intervention that can be offered to the thousands of people found to be HIV seropositive and the costs of counselling and testing will already be being met for reasons other than to provide preventive treatment. As Lucas and colleagues conclude, "outcome in skeletally wasted patients is likely to be unfavourable whatever the cause."[1] Early diagnosis and better management of tuberculosis will eventually reduce the burden of tuberculous infection in the community but cannot be expected to make much immediate impact on the incidence of and associated mortality from slim disease. To define the efficacy and to find innovative ways of delivering preventive treatment and monitoring its cost and impact should be among the priorities of nations where the distributions of HIV infection and tuberculosis overlap.

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Catholic beliefs about contraception

EDITOR,—Dorothy Logie's concern for suffering women and children is fully shared by those of us who are Catholics.[1] Catholic teaching throughout the centuries has been to "love your neighbour as yourself," and this has been manifested by the many hospitals, hospices, orphanages, and schools that Catholics have founded throughout the centuries.

Catholic objections to abortions, condoms, etc are objections not to the laudable end of relieving suffering but to the means of achieving it. For us, killing the unborn is not a legitimate means. Our objection to artificial contraception is based on our belief in the dual purpose of sex—that it is for pleasure and procreation, just as eating is for both pleasure and nutrition so that to eat purely for pleasure with no need of food is gluttony. In addition, I see artificial contraception as the soft option. Natural methods of contraception require men to respect women and their natural cycles by maintaining a monogamous relationship and practising periodic abstinence.

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Waiting times in an ophthalmic outpatient clinic

EDITOR,—The problems facing ophthalmologists in busy units trying to meet the patient's charter have recently been highlighted.[1,2] It seems that the blame must lie with the hospital if the conditions of the charter cannot be met, but this may not always be justified.

Around the time that the charter was introduced I conducted a survey of three general ophthalmological outpatient clinics over three weeks. These were representative morning clinics for a busy, specialised teaching hospital. Overall, 216 elderly patients attended; the most notable finding was that 84 arrived an average of 46 minutes late for their booked appointment time. Trying to fit these patients into the clinics resulted in long delays, with the allotted schedule being overrun. Although a small proportion of the patients were late as a result of ambulance delays, many were late because they were unable to use their reduced fare passes on public transport in the early morning. Because the eye hospital is in a busy city centre, parking problems were also partially responsible. Patients may also be late if they have had to wait many hours to be seen at previous appointments.

The standards in the patient's charter do not take into account factors that may be outside a hospital's control, yet it is the hospital that will be penalised. Perhaps we should impose stricter regulations by informing patients that they will not be seen if they turn up late. This may allow us to meet the standards of the charter but could also result in a number of patients becoming blind unnecessarily.

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Laser treatment of palate results in severe postoperative pain

EDITOR,—Anthony Hinton and Victoria Moore-Gillon write that the recently developed operation of palatal stiffening by laser is less painful than conventional uvulopalatopharyngoplasty.[1] The evidence for this is uncertain as no controlled studies have been carried out, but laser operations on the soft palate are extremely painful, the critical factor possibly being the cutting of muscle with the laser. The pain usually takes two or three days to develop postoperatively but lasts for up to two weeks. Any surgeon planning to perform such procedures must counsel patients about the severe nature of this pain, particularly because patients commonly undergo treatment to benefit others (spouses or partners), with only indirect benefits to themselves. It is therefore advisable to include the partner in such discussions. It is also important that the patient's general practitioner is aware of the severity of the likely postoperative response as he or she will almost certainly be approached for continuing analgesia. Non-steroidal anti-inflammatory drugs are usually most effective, although opiate analgesics may be necessary. Antibiotics are commonly prescribed, but probably only a few patients specifically benefit from them.

Laser treatment of the palate for snoring is likely to increase and holds the promise of relieving severe snoring in a considerable proportion of sufferers. We must be aware, however, of the short term consequences of our surgery.

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GPs' opinions about provision of intrapartum care

EDITOR,—David J Brown's study of general practitioners' opinion on intrapartum care confirms the declining interest in the service.[1] Why is this so when a movement from hospital to community based care is being encouraged[2] and women are apparently demanding a choice?[3] The reasons listed—workload, fear of litigation, and disruption of personal life—undoubtedly provide some explanation. Less is known, however, about women's desire for choice. Does the average woman not demand a choice? Does the typical general practitioner perceive that demand for intrapartum care is insufficient to justify the extra time, commitment, and resources required?

Intrapartum care provided by well motivated general practitioners is undoubtedly safe.[4] These general practitioners, however, are in a minority. Studies of populations of general practitioners include many who claim to offer intrapartum care but assist at few deliveries and perform even fewer procedures. This may jeopardise safety. Women booked for delivery by their family doctor may in practice find themselves delivered by an attached midwife or a midwife they have not met before.[5] This is not the continuity of care that many perceive to be an attraction of delivery assisted by a general practitioner.

The commitment required to provide a good standard of intrapartum care may be unattainable for modern general practitioners. If more intrapartum care is to be based in the community is there not a role for specialist community obstetricians trained by the Royal College of Obstetricians and Gynaecologists? Enthusiastic general practitioners could, with further training, also participate in this service. Provision of intrapartum care by all general practitioners could then take a respectable place in medical history.

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