matters is an entirely different question, and one that its members (or just possibly Her Majesty's Privy Council) will have to decide.

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¹ Anonymous. Clarke heeded the college view. *Current Practice* 1983; Jan 6:3 (cols 2-5).

SIR,—Over the past two weeks I have watched with increasing dismay the overreaction of the General Medical Services Committee to the issue of deputising services. The sight of colleagues vociferously protecting their right to abrogate responsibility for patients is depressing.

It has been perfectly obvious for many years that if the profession was not prepared to get its own house in order then sooner or later the government would do it for us.

To say that our independent contractor status is threatened by Mr Clarke's action is nonsense. It is the action of our colleagues who employ substandard deputies and evade responsibility for patients that will hasten progress towards a salaried service.

I think that most general practitioners in Britain, who arrange their own out of hours cover, will be insulted by the way in which the GMS response has shown us as uncaring doctors who exploit our patients and reject our responsibilities.

This is certainly a resignation issue, but it is resignation from the BMA that I am considering.

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SIR,—The recent issue of the discussion document on deputising has brought a predictable flood of letters to your columns. Almost all your correspondents write as users or critics of commercial deputising services, and no alternative has been considered.

In Wigan we have gathered considerable experience of out of hours cooperation among practices. For six years we have operated a service which, in the absence of any attempt by the Department of Health to understand it, has been forcibly categorised as a deputising service—rather as one would class a tiger as a horse as both have four legs; in consequence we risk being shot along with the rest.

In the course of our existence we have exposed as fallacious several beliefs regarded as holy by those who pontificate on these matters. We have not found non-availability of records to be a great problem; most out of hours calls are for conditions arising de novo, and any competent doctor should be able to elicit sufficient background to avoid getting into difficulties. We have access to our colleagues at all times should need arise, but we seldom need to make use of it. We do not find resentment in patients when their "own" doctor does not appear (sometimes, of course, he does); they are glad to have prompt and ungrudging help, and, as they usually know the identity and origin of the visiting doctor, they are reassured.

A large proportion of our local doctors are doing out of hours work: those who are not are, in general, older, or women with young families, or in indifferent health. It seems to

us to be irrelevant that instead of making 20 out of hours calls in the course of a month, they make them in one or two six hour periods. Our family practitioner committee and community health council have expressed satisfaction and confidence in the service we are giving; no official complaint has arisen from it in six years. A professional advisory committee has been set up, but as all local doctors take part in this scheme the mechanism of the committee has not seemed very appropriate as we would be in the position of "vetting" one another. Hence since 1978 the family practitioner committee has had a mixed lay and professional subcommittee, monitoring out of hours work on exactly the lines now proposed.

We believe that we have a sensible sound, and effective system, appreciated by our patients; had such systems been adopted more widely in the past few years instead of out of hours work being delegated to bodies outside the direct control of family practitioner committees, the discontent that has led to the issue of the minister's document might never have arisen.

F G INCE

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SIR,—In your correspondence about deputising services the consumer's point of view has not been given. As an ex-general practice principal (who did not use such a service), now a hospital doctor, I would like to comment. When I moved to a new area an important task was not only to find a good general practitioner but, as one doctor can not be on call 365 days a year, I had to assess his partners and any doctors with whom they worked a rota to find a good practice. An important consideration was to find a practice that did not use a deputising service.

This is partly for the positive reason that if one of my family or I is ill we like to see a doctor we have met before and trust, but also for negative reasons as there are some doctors I do not want to see. There are some whose competence I doubt and others I do not trust; some whose appearance and manner inspire no confidence, and others I may not get on with. I do not deny the need for deputising services in some areas but get one thing straight—the patient does not like them.

Writing as an accident and emergency consultant, I note that two of your correspondents (A C Houghton and Leone Ridsdale, 21 January, pp 229, 232) again raise the question put last year as to whether the GP out of hours service should be based on the accident and emergency department. Although not averse to a bit of empire building (so long as I can control who works in my department) I foresee major problems. Some conditions—for example, otitis media, angina, and cystitis—can be and are well treated at home. Others—for example, epiglottitis, cardiogenic shock, and acute retention of urine—need hospital admission. Lastly, there is an in between group of patients—for example, with croup, myocardial infarction in the elderly, and renal colic—who can be treated perfectly adequately at home but who have to be admitted if seen in the accident and emergency department.

The practical problems of an out of hours service based in hospital may not be insur-

mountable but the hidden costs would be considerable.

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¹ Kellerman F. Is your deputising service really necessary? *Br Med J* 1983;287:882.

** We have received six other letters on deputising services: five are critical of the government's proposal, and one repeats the suggestion that out of hours cover be based in casualty departments in local hospitals.—Ed, *BMJ*.

Post-transfusion hepatitis after cardiac surgery

SIR,—In their study of non-A non-B post-transfusion hepatitis Dr J D Collins and others (12 November, p 1422) found an incidence of only 3.2% among patients undergoing cardiac surgery. This figure is lower than the 7-10% incidence generally reported for post-transfusion hepatitis.¹ We do not believe that the authors are justified in their conclusions owing to the design of their study. Most of their patients (82%) were studied for a maximum of only 30 days after operation and then again (on a single occasion) at six months. Although the 30-day follow up period could have identified cases of short incubation, non-A non-B post-transfusion hepatitis,² only a small percentage of the cases of post-transfusion hepatitis reported in the studies referred to by the authors³⁻⁵ would have been detected within a four week period. A recent review on non-A non-B hepatitis mentions that the incubation period is five to 12 weeks for more than 80% of cases.¹ Furthermore, the duration of appreciable rise in transaminase activity may be relatively short; less than 16 weeks in most cases in one study⁶ and a mean of 10.4 weeks in another.⁷ Thus many of the patients studied by Collins would have been expected to have recovered by six months.

Dr Collins and his colleagues attempt to make up for the lack of periodic biochemical testing between one and six months in most of their patients by extrapolating the data obtained from 44 subjects chosen solely on the basis of geographic convenience. We have serious reservations that these few patients adequately represented the entire group.⁷ Moreover, the authors' reliance on patients or their practitioners to report symptoms of overt hepatitis is apt to be misleading in view of the high incidence of asymptomatic disease in non-A non-B hepatitis.¹ The incidence of chronic hepatitis (as detected by a single assay at six months) may also have been spuriously low, as it is well known that transaminase values may fluctuate widely during the course of post-transfusion hepatitis.¹

We agree that the interpretation of raised transaminase activities after cardiac surgery is often difficult. Without monitoring of hepatic enzymes at regular intervals in all patients for at least six months, however, several instances of post-transfusion hepatitis may have gone undetected.

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- ¹ Dienstag JL. Non-A, non-B hepatitis. I. Recognition, epidemiology, and clinical features. *Gastroenterology* 1982;85:439-62.
- ² Hruby MA, Schauf V. Transfusion-related short-incubation hepatitis in hemophilic patients. *JAMA* 1978;240:1355-7.
- ³ Grillner L, Bergdahl S, Jyräla A. Non-A, non-B hepatitis after open-heart surgery in Sweden. *Scand J Infect Dis* 1982;14:171-5.
- ⁴ Katchaki JN, Siem TH, Brower R, Van Loon AM, Van Der Logt JThM. Post-transfusion non-A, non-B hepatitis in the Netherlands. *Br Med J* 1981;282:107-8.
- ⁵ Alter HJ, Purcell RH, Holland PV, Feinstone SM, Morrou AG, Moritsugu Y. Clinical and serological analysis of transfusion-associated hepatitis. *Lancet* 1975;iii:838-41.
- ⁶ Tateda A, Kikuchi K, Numazaki Y, Shirachi R, Ishida N. Non-A hepatitis in Japanese recipients of blood transfusions. Clinical and serological studies after the introduction of laboratory screening of donor blood for hepatitis B surface antigen. *J Infect Dis* 1979;139:511-8.
- ⁷ Swinscow TDV. *Statistics at square one*. London: British Medical Association, 1981:16-20.

* *Two of the authors reply below.—Ed, *BMJ*.

SIR,—We thank Dr Arenson and his colleagues for their comments.

We agree that the incidence of 3.2% of patients developing possible post-transfusion hepatitis in our study is lower than the 7-10% incidence quoted from many non-European centres by Dienstag.¹ Our figure does, however, agree well with the 3.9% incidence found by the previous British study carried out by the Medical Research Council.² It is also in accord with the figure of 3.4% found in a similar study from the Netherlands.³

The main thrust of the letter from Dr Arenson and colleagues is that we may well have missed a number of cases of non-A, non-B post-transfusion hepatitis of longer incubation because of the way in which our study was carried out. We were careful to state that this was the case, but we suggest that our main conclusion—namely, that the incidence of appreciable chronic liver disease after blood transfusion was extremely low—is indeed valid. Although we accept that a small number of patients could have developed a transient rise in serum transaminase activity between 30 days and six months after transfusion several studies show that more than half of such patients continue to have abnormal results of liver function tests after six months⁴ and these have chronic liver disease.⁵ The fact that we found only one or at most two such patients is reassuring, as it suggests that only a small number of patients did indeed develop possible non-A non-B post-transfusion hepatitis in this period. If a large number—perhaps up to 10% of the patients as suggested by Arenson—had developed this longer incubation post-transfusion hepatitis we would have expected to see more patients with abnormal liver function values at six months.⁶

We agree that the design of our study was imperfect in that blood samples were not taken from on all patients every two weeks, but we suggest that the absence of raised transaminase concentrations in any of the 44 geographically selected patients who were so tested is also reassuring.

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- ¹ Dienstag JL. Non-A, non-B hepatitis. I. Recognition, epidemiology, and clinical features. *Gastroenterology* 1982;85:439-62.
- ² Medical Research Council Working Party on Post-transfusion Hepatitis. Post-transfusion hepatitis in a London hospital: results of a two-year prospective study. *J Hyg (Camb)* 1974;73:173-88.

- ³ Katchaki JN, Siem TH, Brower R, Van Loon AM, Van Der Logt JThM. Post-transfusion non-A, non-B hepatitis in the Netherlands. *Br Med J* 1981;282:107-8.
- ⁴ Aach RD, Lander JJ, Sherman LA, et al. Transfusion-transmitted viruses: interim analysis of hepatitis among transfused and non-transfused patients. In: Vyas GN, Cohen SN, Schmidt R, eds. *Viral hepatitis*. Philadelphia: Franklin Institute Press, 1978:383-96.
- ⁵ Rakela J, Redeker AG. Chronic liver disease after acute non-A non-B viral hepatitis. *Gastroenterology* 1979;77:1200-2.
- ⁶ Grillner L, Bergdahl S, Jyräla A. Non-A non-B hepatitis after open heart surgery in Sweden. *Scand J Infect Dis* 1982;14:171-5.

Withdrawal of fluorescein strips

SIR,—Many ophthalmologists have been in the habit of using small fluorescein-impregnated paper strips, manufactured by the Haag-Streit company, during applanation tonometry. These have now been withdrawn from the market because they are apparently classified as a drug and therefore the instrument manufacturers are not permitted to supply them.

I rather thought that the drug laws were concerned with drugs that were supplied to the public. I am surprised to find that a product which is used exclusively by doctors during the course of their own diagnostic procedures should come under a legal ban. In this particular case, the ban is rendered all the more absurd by the fact that the substitute one might have recourse to is fluorescein drops, which are known to be far more dangerous than impregnated paper strips (due to their habit of harbouring the pyocyanous organism).

Thus bureaucracy is impeding the diagnostic process with no apparent benefit that I can see. Do you think that anything can be done about it?

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* *We sent this letter to the Committee on Safety of Medicines.—Ed, *BMJ*.

SIR,—The Medicines Act 1968 is, of course, not confined to drugs that are supplied to the public but covers all products for a medicinal purpose. Medicinal purpose as defined in the Act (section 130(2)(b)) expressly includes diagnosis. Thus we had no alternative to informing the company that imports the Haag-Streit strips that they were required to apply for licences: this they have, in fact, done. There is, however, another fluorescein strip product (Fluorets) on the market produced by another company that has a licence.

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Screening for hypertension in general practice with an automatic machine

SIR,—I would like to take issue with the conclusions drawn by Dr W P Stephens and others (26 November, p 1600) from the results presented in their paper.

From their study they appear to derive a two-fold message. Firstly, that electronic measuring devices are not appropriate for screening patients for hypertension and, secondly, that case finding by routine measurement of blood

pressure on surgery visits is a more efficient means of detecting previously undiagnosed cases.

The figure of 4% of their screened population found to have values considered to be above the normal range at the first manual reading is in line with that reported in my recent paper, where just over 5% of new cases were detected by open access screening,¹ but Dr Stephens and colleagues did not recognise the importance of systolic hypertension.^{2,3} It therefore cannot be said on the basis of their published figures that as a method for detecting possible cases of previously undiagnosed hypertension either electronic instruments or screening programmes are inefficient.

The lack of success they reported is almost entirely related to the nature and results of their follow up programme, and from the published information it is not possible to assess what factors may have produced the lack of response. It may be, for instance, that the use of a doctor from outside the practice had a negative effect or that the times when screening was available tended to exclude those people in employment. The lack of a clear predetermined level of blood pressure above which the patient would be referred may have been another negative factor. I am also startled by the phrase: "The automatic machine conveys an alarming figure to the patient with no reassurance at all." Surely it should be the function of the technician or nurse in charge to make sure that this does not occur.

In conclusion, I suggest that Dr Stephens and his colleagues provide evidence in support of the use of electronic instruments and a formal screening programme for the detection of previously undiagnosed cases of hypertension, but they also valuably draw our attention to the difficulties of following up the patients so detected.

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- ¹ Gordon H. Screening for hypertension. *Br Med J* 1983;287:659-62.
- ² Kannel WB, Gordon T, Schwartz MJ. Systolic versus diastolic blood pressure and risk of coronary heart disease: the Framingham study. *Am J Cardiol* 1971;27:335-46.
- ³ Kannel WB, Dawber TR, McGee DL. Perspectives of systolic hypertension: the Framingham study. *Circulation* 1980;61:1179.

* *The authors reply below.—Ed, *BMJ*.

SIR,—Dr Gordon's study and our own are two early explorations of the value of automatic devices to screen blood pressure in the detection of unrecognised hypertension. The two studies approach the problem differently and, not surprisingly, have reached different conclusions.

We used Vita-Stat to select patients from a defined population (a health centre) for later manual measurements of blood pressure. The presence of doctors from outside the practice cannot have contributed to the disappointingly low attendance rate of 55% at the automatic screening because WPS and RDGT were not involved at that stage. In fact, once the recalled patients knew they were seeing an "outside doctor" the rate went up to 83%. We acknowledged in our paper that opening hours determine the number of patients seen. Opening hours were dictated by local practicalities, however, and in this respect would differ little from the opportunities