and especially in KwaZulu, the Zulu homeland, we have an extreme shortage of medical staff. The KwaZulu Department of Health has divided itself into six regions, each of which contains about five wards centred on their own hospital. Specialists are based at the regional hospitals but are encouraged to visit the ward hospitals for teaching and to provide services. The ward hospitals are rural. Around each ward hospital is a network of residential clinics staffed by nurses trained in primary health care. Patients with conditions beyond the nurses' competence are referred to the ward hospital for care. Rural hospitals are therefore very much part of the community, and a good rural physician can have considerable contact with the local people.

Because the rural hospitals are up to 200 km from the regional hospital the doctors staffing them are general practitioners in the true sense and have great clinical responsibility. Rural doctors also manage the hospital. Our department's policy is to allow management to be done by the local team of medical superintendent, matron, and administrator. This gives the physician additional opportunities to develop programmes of care and even research programmes. The physician can also learn the art of management.

I would like to appeal to young recently qualified doctors and to older doctors (who in South Africa are highly valued and do not retire at 60) to come to KwaZulu to work. Many of my colleagues are in their 70s, and I am sure that their continued work stimulates them and keeps them young in spirit. Anyone interested can contact me at Private Bag X 10, Ulundi 3838, or by facsimile (0358 202439). All letters will receive a personal reply.

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1 Chambers R. Avoiding burnout in general practice. *Br J Gen Pract* 1993;43:442-3.

Management of acute symptomatic hyponatraemia

EDITOR,—Christopher Heneghan and colleagues discuss the management of hyponatraemia during transurethral resection of the prostate.¹ Having been a urologist throughout my career, since my retirement I have acted as reviewer for legal assessment firms. I have been impressed by certain recurring patterns that may be important.

Acute hyponatraemia after transurethral resection of the prostate is known to increase with the duration of the operation, which, with experienced operators, usually implies excessive venous bleeding that has been resistant to control. In many such cases in which litigation is threatened, a careful examination of the case notes reveals a record, sometimes tucked away in the nurse's or house officer's history, that the patient is taking daily aspirin. Absence of a note does not rule this out. Daily aspirin can be fatal. If the irrigant used contains mannitol or sorbitol (seldom nowadays) and the hyponatraemia is not immediately remedied, pulmonary oedema often follows. Cerebral oedema and renal failure ensue often.

Faced with the early signs of distress mentioned by Heneghan and colleagues, a wise urologist immediately gives hypertonic saline. Not much is needed to produce dramatic improvement. Unfortunately, in panic, some surgeons do turn not to fellow urologists for advice but to "internists," who are adept at treating chronic hyponatraemia as it is a familiar problem to them. This is physiologically a different condition, for which they often advocate use of diuretics. In acute

hyponatraemia the delay in treatment often leads to an unfortunate outcome and devastating litigation in the United States. Ask about aspirin before surgery.

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1 Heneghan C, Goldrick P, Pham H. Management of acute symptomatic hyponatraemia. *BMJ* 1994;308:203. (15 January.)

Emergency radiography of the ankle

EDITOR,—D O'Keeffe and colleagues give advice on emergency radiology of the ankle.¹ Recent work by Stiell *et al* has greatly refined the indications for x ray examination of patients who have injured their ankle.^{2,3} The guidelines resulting from Stiell *et al*'s studies (that is, obtain an x ray film in patients unable to bear weight for four steps both immediately and in the emergency department or with bony tenderness at the posterior edge or tip of either malleolus—though there are exclusions) are clear, brief, and thus easily remembered and readily used by doctors and nurses assessing the need for x ray examination of the ankle.

Implementation of the guidelines in an audit project in my department has reduced the percentage of patients with ankle injuries undergoing radiography of the ankle by an estimated 28%. The authors claim a 100% sensitivity for their selection criteria, and this is supported by our experience over the 11 months we have used the criteria.

Radiography of the ankle is common in accident and emergency departments, and the refinement of selection criteria clearly benefits patients, budget holders, and junior doctors trying to learn a lot in a short time.

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Infant death and consanguineous marriage

EDITOR,—The finding of a higher infant mortality in Pakistani immigrants than in the indigenous population in Norway¹ is similar to the findings of the Yorkshire infant mortality study, which took place for 22 months from 1 April 1991.² Analysis on ethnic group was carried out for the nine districts for which denominators were available—namely, Airedale, Bradford, Calderdale, Dewsbury, Harrogate, Huddersfield, Leeds, Scunthorpe, and York. These districts had a total of 65 680 births in the 22 months, of which 6933 were to Asian mothers, mostly of Pakistani origin.

The overall postperinatal mortality was 7.36/1000 for Asians and 4.06/1000 for non-Asians. This difference resulted mainly from the higher incidence of congenital and metabolic abnormality among Asians, although deaths from perinatal problems were also more common (table). These figures do not include deaths in the first week of life, which are likely to have accentuated these differences. We did not collect data on consanguinity, but autosomal recessive conditions were

Postperinatal mortality in white and Asian infants

	White		Asian	
	Rate/1000 live births	95% Confidence interval	Rate/1000 live births	95% Confidence interval
Perinatal factors	0.599	0.412 to 0.841	1.587	0.792 to 2.837
Congenital abnormalities	0.835	0.611 to 1.113	3.173	1.990 to 4.800
Metabolic disorders	0.054	0.011 to 0.159	0.865	0.318 to 1.883

relatively common among Asian families. This is being examined in more detail by a study in Bradford in conjunction with the National Perinatal Epidemiology Unit.

After the recent fall in the incidence of the sudden infant death syndrome we suggest that the next major reduction in infant mortality in populations that include a high proportion of Pakistani families may be achieved by greater emphasis on and acceptance of genetic counselling and antenatal diagnosis. As in previous reports,^{3,4} we found the sudden infant death syndrome to be much less common among Asian than white infants (0.14/1000 live births *v* 1.25/1000). This, together with the greater frequency of metabolic abnormality in Asian families, suggests that when an Asian baby dies unexpectedly metabolic investigation is particularly important.

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- 1 Orstavik KH, Lindemann R, Steen J. Infant death and consanguineous marriage. *BMJ* 1994;308:659. (5 March.)
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Haematuria clinics

EDITOR,—In their editorial on haematuria clinics Philip Marazzi and Roger Gabriel¹ comment on our study of a haematuria clinic² and raise two points on which we would like to comment. Firstly, they comment on the apparent absence of urinary infections in 105 patients with prostatic hyperplasia and cancer, urolithiasis, and urethral stricture. We considered urinary tract infections in these patients to be secondary to those conditions and did not report them separately. In fact, seven of these patients had urinary tract infections proved on culture, and many had received antibiotic treatment from their general practitioner before coming to our clinic.

Secondly, we agree that widespread dipstick testing of urine in general practice can overload haematuria clinics such as ours. We studied the activity of this clinic for the two months July and August 1993 (that is, two years after the end of the period reported in our previous study). In this time 28 patients attended the clinic. Eight (29%) had microscopic haematuria, compared with 53 (17%) of 304 patients in the earlier period. Not surprisingly, the proportion with no demonstrable pathological finding on investigation was higher in the second period. In our earlier study we reached no diagnosis in 61 (20%) of the 304 patients, while in the second period this proportion had risen to 13 (46%) of the 28 ($P < 0.01$, χ^2 test). The aim of our haematuria clinic was to expedite the investigation

of haematuria, but this aim had suffered in the two years between the studies. In our first study the mean delay between referral and the clinic appointment was 23 (SD 14.6) days; by July 1993 this had risen to 40 (27.3) days ($P < 0.001$, Mann-Whitney test).

As Marazzi and Gabriel point out, the correct use of haematuria clinics demands selective referral. Our present practice is to arrange ultrasonography on an outpatient basis for patients with microscopic haematuria and to examine its results before considering the merits of cystoscopy in each case. The "fast track" of our haematuria clinic is reserved for patients with frank haematuria.

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1 Marazzi P, Gabriel R. The haematuria clinic. *BMJ* 1994;308:356. (5 February.)

2 Paul AB, Collie DA, Wild SR, Chisholm GD. An integrated haematuria clinic. *Br J Clin Pract* 1993;47:128-30.

Purchasers, professionals, and public health

Criticisms of Abrams report are misdirected...

EDITOR,—Andrew Harris and Jonathan Shapiro's strident criticisms of the tunnel vision of the Abrams report are misplaced.^{1,2} Their analysis shows naivety and a lack of understanding of the real imperatives in public health. The ire that they direct at the Abrams report—without any explanation to readers of what it recommends—is misdirected. Sadly, the narrow focus of the report is needed since the government has shown little legislative commitment to public health.

Moreover, local evidence suggests that mergers of district health authorities and family health services authorities, instead of strengthening public health, have in some cases resulted in a "rationalisation" and loss of public health resources in the name of economies of scale. But the authors' most glaring error is to have equated the public health function with the purchasing activity of district health authorities and family health services authorities. Have they forgotten that most health is gained or lost outside the NHS?

The authors should not let their personal views of public health physicians cloud the real issues about the importance of securing an independent public health voice for local populations. Our energies should be directed instead at developing local alliances to ensure that the real public health issues are still heard. When we have secured this let us argue about the qualifications for leadership in public health.

The Abrams report, while it missed an opportunity to recommend how local public health alliances might be strengthened, should not be held solely responsible for this omission. Its predecessor, the Acheson report, focused almost exclusively on the role of public health physicians.³ Neither report has helped health authorities to build strong, multidisciplinary links with either primary care or, more importantly, local authorities, whose services have a much greater impact on health than the NHS. Responsibility for this lies with the creation of the internal market, within which we have had to recreate links with local authorities and others. We have even in-

vented a new term for this old activity: joint commissioning.

Finally, the authors' suggestions for generating greater public health support for providers and smaller purchasing units must be set against the costs of doing so. Our first priority must be to our whole population. Commitment to smaller populations through fundholding or provider support has to be weighed up against the opportunity costs and the benefits or disbenefits to health.

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1 Harris A, Shapiro J. Purchasers, professionals, and public health. *BMJ* 1994;308:426-7. (12 February.)

2 Department of Health. *Public health: responsibilities of the NHS and roles of others: advice of the committee set up to undertake a review of HC(88)64*. London: DoH, 1993. (HSG(93)56.) (Abrams report.)

3 Committee of Inquiry into the Future Development of the Public Health Function. *Public health in England*. London: HMSO, 1988. (Acheson report.)

...and unfair

EDITOR,—Andrew Harris and Jonathan Shapiro criticise the findings of the Abrams committee and contemporary public health medicine.¹ They criticise the "narrow" membership of the Abrams committee despite the fact that there was a minority of public health physicians in the group, which included chief executives of NHS trusts and authorities, a chief executive of a county council, a director of social services, and a general practice fundholder. They are correct in saying that the report reaffirmed the role of the director of public health as having responsibility for the surveillance of an improvement in the health of the resident population. This finding is to be commended as such a role is needed. Mergers of health authorities, the introduction of trusts, and changes in local government have confused lines of responsibility.

Their second point is the need for clinical advice and the assumption that public health physicians see themselves as suited to providing such advice. Public health physicians have an important corporate role within organisations such as health commissions to appraise critically and to interpret clinical information. Clinical advice should be given only by practising clinicians, which means that former general practitioners acting as medical advisers can no longer be clinical advisers but, like public health physicians, provide professional advice.

The authors' third main point is their concern that the growth in interest in primary care will be reversed by the Abrams report and the endorsement of the function of directors of public health. The Public Health and Primary Care Group, of which I am an executive member, shares the concerns about the knowledge and skills currently available in public health medicine. With the merger of family health services authorities and district health authorities, however, the relevance of primary care has become obvious, and the training needs of public health trainees and consultants are acknowledged. This is enhanced by more contact with primary care medical advisers and other professional advisers, who will continue to have an important role. Clarity about respective roles and responsibilities will help to avoid the professional territorialism to which the authors draw our attention.

Finally, there is a distinction between public health and public health medicine in the same way that there is a difference between primary care and general medical practice. Multidisciplinary teamwork in both settings is needed. Both general practitioners and public health physicians have lead roles in their respective arenas despite the broader definitions. When in the future the relative

power of the medical professional is reduced then leadership by medical professionals will change too.

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1 Harris A, Shapiro J. Purchasers, professionals, and public health. *BMJ* 1994;308:426-7. (12 February.)

Specialty has been misunderstood

EDITOR,—Andrew Harris and Jonathan Shapiro paint a confused and misleading picture in their editorial on the public health function.¹ Many of their comments on the Abrams report² show a serious misunderstanding of the role of public health medicine. For example, it is fallacious to state that the complex guidance on controlling communicable disease is more about securing jobs than about protecting the public. Probably only those who have dealt with a serious incident of infectious disease can appreciate how complicated the problems are. A reading of the reports of the public inquiries into the major outbreaks of communicable disease at Stanley Royd Hospital in 1984 and in Stafford in April 1985 might assist understanding.^{3,4} Given the number of different organisations involved, failure to have watertight mechanisms for controlling communicable disease would be to court disaster.

The editorial states that the Abrams report reverses the move towards a health service focused on primary care. The report does nothing of the sort, and to believe that it could have that effect on such a central and widely supported policy objective is foolish. Harris and Shapiro show concern on behalf of doctors working in family health services authorities. Their concern might find better expression if they argued that the emerging hybrid district health authority-family health services authority should have doctors with recent experience of general practice on its staff. The role of advising on general practice matters is important but differs substantially from the practice of public health medicine. There is no reason why the two cannot coexist in harmony.

Those of us working in public health medicine are familiar with the tension that exists between providing independent professional advice and participating in managerial decision making. Public health practitioners rely on their personal and professional ethics in responding to conflicting pressures. The authors of the editorial do not adduce any evidence for their statement that the position of consultants in public health medicine is untenable. Improvement in public health has always required action as well as analysis, and participation in management is unavoidable.⁵ Because of this the independence of the annual report of the director of public health and the freedom to write, publish, and broadcast are important and need to be defended.

It would be arduous and probably nugatory to respond to all the ill founded assertions made by Harris and Shapiro. Debate is welcome on issues such as whether the Faculty of Public Health Medicine should be opened fully to non-medically qualified colleagues, but now is not the time for navel gazing. The list of unsolved public health problems demands a vital and energetic response, and I am convinced that public health physicians will be in the vanguard.

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1 Harris A, Shapiro J. Purchasers, professionals, and public health. *BMJ* 1994;308:426-7. (12 February.)

2 Department of Health. *Public health responsibilities of the NHS and roles of others: advice of the committee set up to undertake a review of HC(88)64*. London: DoH, 1993. (HSG(93)56.) (Abrams report.)