surgery that improves quality of life only to those patients who are confirmed to have stopped smoking.

I wish to examine their rationale, deduced from the editorial, for this position: in their previous work they have found that a desirable clinical end point (patency of a graft after one year) is higher in non-smokers; several observational studies of various arterial graft interventions show that "adverse outcomes" are associated with continued smoking; and patients can choose to stop smoking. More appropriate end points would include survival, quality of life, and the viability of the affected limb. For the authors' chosen end point, however, the patency of the (femoropopliteal) graft is found to be higher in non-smokers (84%) than smokers (63%) one year after surgery. These data are based on only 157 of the original 293 participants in a trial: what happened to the remaining 46% of the participants?

Association does not equal causation. The causal mechanisms are not fully understood and are probably complex and multifactorial. Observational studies are useful for suggesting causal factors, but, so that people can make the greatest use of them, a systematic review of relevant studies, presenting positive and negative findings, should be collated. As "tobacco seriously damages health," smoking tends to be assessed in a wide range of studies into health. Not surprisingly, associations are commonly found. Other associations are also commonly found: most diseases show differential survival by gender, but does this mean that expensive interventions should be offered only to women?

Symptoms will probably be reduced or the patency of a graft improved, or both, if patients stop smoking. Obviously, patients should be given this information. But smoking helps people to cope with stress and is extremely addictive—so much so that people have been known to choose cigarettes in preference to food. Not everybody will be able to give up this support even when faced with the prospect of losing a limb.

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Using rapid appraisal to assess need

Inappropriate in inner cities

EDITOR,—The endeavour to link community perceptions of need to local provision of services is laudable, but there are difficulties with the general applicability of the modified rapid appraisal technique outlined by S A Murray and colleagues.¹ The practice based model described was used in an estate with a homogeneous, stable community, half of which was served by a single general practice. In our experience of needs assessment in two small inner city wards in the west end of Newcastle we have encountered highly mobile populations (21% of residents had moved house in the previous year)² and diverse ethnic populations served by 16 general practices.

Given the many service providers from many different agencies and the range of specific needs of diverse groups of people, the method outlined would not be appropriate in these localities. To gain insights into the needs of traditionally excluded groups we are training local people with

appropriate language skills to gather information. We are also promoting cooperation by convening regular meetings of local agencies. Recommendations for modifications to services will be made at a locality level and implemented by the local purchasing authority's service specifications.

The link between needs assessment and the purchasing cycle is critical if local perceptions are to be acted on. But the diversity of local needs and the priorities and concerns of all sections of the local community, including those less easily identified, must be addressed.

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Listen to local voices when planning services

EDITOR,—S A Murray and colleagues report the use of rapid appraisal to assess health and social needs in general practice.¹ We recently used rapid appraisal in a survey in one of the deprived communities in the midlands.

Our survey showed that the pressures of low income, unemployment, law and order, and a generally insecure local environment were ranked well above any associated with health issues. Two of the most widely expressed concerns in relation to local services, including health services, were lack of information and perceived difficulties of access. In addition, in the categories of disease and disability and the physical environment there were appreciable differences in the ranking of issues between informal informants (local residents), and formal informants and surveyors. As many of the formal informants and most of the survey team were local community service staff, these discrepancies indicate potentially important differences in priorities between planners and providers of services and their clients.

The detailed report, written by the survey team, is being used as the basis for action and planning by a local multiagency group, set up to coordinate responses to local needs, and by all of the relevant community services (health authority, family health services authority, combined health care, police, city council, and social services).

The enthusiasm with which the survey and the report were received by the local community and community services was a strong indication of the need to listen to local voices when planning and delivering local services. Equally, it is clearly inappropriate to act on assumptions that local needs priorities are known. To do so would tend to perpetuate conditions that impair the capacity of the members of such communities to respond to health promotion messages and further lessen their belief that services are set up with their expressed needs in mind.

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Sensitivity to latex

EDITOR,—We were interested in P I Mansell and colleagues' report of a severe anaphylactic reaction to latex gloves¹ as we are investigating reports of contact urticaria, anaphylaxis, and related responses among medical and dental health care workers and dental patients on exposure to latex in the practice and provision of dental and medical care.² Given the apparent increase in such adverse reactions to contact with latex and the increasing use of latex gloves in clinical work,³ we believe that all people who wear latex gloves and use latex products should be aware of the possible hazard to some patients of contact with latex. The number of people affected is small in relation to the high use of latex products, but the potential severity of the anaphylactic reactions led the United States Food and Drug Administration to issue a medical alert.⁴

We suggest that practitioners who wear latex gloves in their clinical practice should routinely ask patients if they have ever experienced any rash or itching after contact with balloons, condoms, rubber gloves, or any other products containing latex. Practitioners should also be aware that health care workers, those who work in the latex industry, people with substantial exposure to products that contain latex (such as catheters), and people with a history of atopy may be at increased risk of allergic or anaphylactic reactions on exposure to latex.⁵ Furthermore, previous unexplained allergy or unexplained anaphylactic reactions during a medical or dental procedure may indicate sensitisation. Finally, practitioners should use alternatives to products that contain latex when they examine or treat patients considered to be sensitised to latex.

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South Africa needs doctors

EDITOR,—While in Britain recently I was saddened by the apparent malaise in the NHS and doctors' unhappiness with their lot. A survey conducted by the Royal College of General Practitioners is quoted as having found that 25% of general practitioners had positively considered leaving general practice and 45% wished to retire at age 55 because of disillusionment with general practice.¹ In contrast, although South Africa is going through a period of rapid change and uncertainty, there is no such medical malaise. I have found my work here to be stimulating and professionally satisfying, and it is exciting to help develop a new system. Previously the health services have been fragmented owing to the dogma of apartheid, but we are now creating a new, unified and community based service. In both Britain and South Africa the medical services are undergoing a revolution, but that occurring in South Africa is giving those of us working here an opportunity to correct past injustices and to contribute to the process of change.

In the South African hospital medical service,