make a legitimate protest without fear or favour is no longer considered wise.

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2 Butt G. Iraqi doctors face climate of fear. *BMJ* 1994;309:898. (8 October.)

Unanimity in the profession

Don't pretend to be unanimous

EDITOR,—The first two editorials in the issue of 29 October sit strangely together. While the first, by Ian Morrison and Richard Smith, takes an imaginative view of the future,¹ the second, by Tony Grabham, is a fine example of the authoritarian and corporatist attitude that has characterised "doctors' leaders" for too long.² Morrison and Smith urge doctors to see themselves as part of a wider society, characterised by sophisticated consumers and shifts in the boundaries of health and medicine. Grabham, however, reminisces back to the days of Harold Wilson and Barbara Castle, when a display of professional unity apparently influenced government policy.

If the profession is unanimous then there is no point arguing for unanimity. If it is not then the pretence of unanimity is a deception. I reject the notion that breaking ranks and expressing a contrary view is wrong. It is about time that medical leaders (and the public) stopped regarding medicine as a professional island, unaffected by the tides of social change. On the contrary, as doctors we reflect the range of opinion present in the society from which we are drawn. Doctors therefore have every right to express personal views publicly, even when these are at variance with those of the ruling medical cabal. When I was a medical student in Johannesburg I marched in the streets in defence of academic freedom, and I will continue to oppose any threat to this principle, whether from the government or from professional leaders.

Policymakers are entitled not only to information on the majority view in the profession but also to the degree of unanimity and the reasons behind opposing medical viewpoints. Grabham is right that medical representatives are fragmented. An academy of medicine based on the royal colleges and elected representatives would form a useful point of contact between the government and the profession and a forum for reasoned argument, particularly in cases in which consensus is absent. Such an academy should not simply try to paper over the cracks of inevitable and healthy division of opinion.

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2 Grabham T. Divided we fall (yet again). *BMJ* 1994;309:1100-1. (29 October.)

Any academy should stay away from realpolitik

EDITOR,—When Tony Grabham confines himself to ethical issues (incidentally, I believe that performance related pay in medicine is primarily an ethical issue) I broadly agree with his view that the profession needs to present a united front.¹ The BMA's ethical committee has worked wonders over the past few years, but the BMA's council does not provide the ideal forum in which to debate

the broad issues: time for reasoned debate is rarely adequate, the adversarial presentation of amendments and riders is often too restrictive, and the council anyway is predominantly politically oriented. A policy forming body combining as its basis the views of the General Medical Council, the royal colleges, and the BMA would certainly be more authoritative and possibly more effective as well.

But the thought of such a body concerning itself with realpolitik is another matter. Firstly, the government would seize on it as the ultimate longstop, declining to make any important medicopolitical decisions until they had been referred to this particular committee; this would effectively emasculate the standing committees of the BMA, which over the years have been remarkably effective. Secondly, the committee, elected I know not how, would have a high proportion of academics, who are not renowned for their political wisdom, and if truly representative would be vast. Almost by definition the members would be "yesterday's men" and disproportionately old. The committee could be answerable only to its constituent parts, which on many issues would be at variance with each other, and the mind boggles at the thought of drawing up a timetable when all the members would be free to meet.

I accept that politically the profession has not done well over the past few years, but we have only ourselves to blame. The BMA represents more than three quarters of the medical profession in Britain; if its members are agreed on a policy, and if it has wise and resolute leadership, its forces are irresistible and there is no need for yet another committee to be interposed between it and the government.

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The future of public health

Further economic growth may not improve health

EDITOR,—I dispute Raj Bhopal's contention that further rises in economic strength are necessary to improve the nation's health.¹ This rests on two assumptions: firstly, that further increases in gross national product will lead to further increases in health and, secondly, that when a country becomes more prosperous all its citizens benefit equally. I believe that the first will not hold true in the future, while the second is clearly not true even now, socioeconomic differences in health being well recognised.²

It is indisputable that higher living standards have made us healthier over the past century, but is it possible to say that this relation will hold for the future? Most of us already enjoy a more than adequate standard of living, and I cannot understand how further increases in the national wealth will make us healthier still. On the contrary, I suggest that these would be positively damaging to our health, for the creation of wealth depends on industrial processes that increase environmental pollution, and the extra spending power that results tends to be used not on items that enhance health but on new cars and consumer goods that contribute to our society's ever increasing energy consumption. Furthermore, as the resources on which even our current lifestyle depends are finite, that lifestyle, with its health benefits and material benefits, is ultimately unsustainable. Further increases in consumption, which the politicians' talk of exponential economic growth implies, would merely bring closer the point at which our

raw materials are exhausted while worsening both our health and our quality of life.³

The relation between the environment, income, and health is now being reflected in the scope and activities of public health as a discipline,⁴ but all clinicians see the effects on health of our sick environment. Surely we should be working towards industrial, employment, transport, and building policies that develop sustainable ways of living without depleting the earth's resources. Doctors proved themselves surprisingly political in the fight against smoking. Will they take arms against similar big business interests and government inertia to clean up our environment and encourage them to promote ways to make us healthier, though not necessarily wealthier, in the years to come?

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Evidence based public health

EDITOR,—I am surprised that Stephen Watkins thinks that those who seek "objective measures of health gain, efficiency, and effectiveness" are a threat to public health.¹ In his opinion this model is a poor substitute for professional judgment because "not all human experience is measurable in numbers, and that which is not may be more important than that which is." Surely, many of the most important aspects of human experience relevant to public health—namely, death, disease, and disability—can be measured. As for the rest, I concur with Lord Kelvin's observation: "until you have measured it, you don't know what you are talking about."

In their editorial on the future of medicine Ian Morrison and Richard Smith argue that evidence based medicine will transform the practice of medicine.² I would argue that professional judgment in the absence of data is a poor basis for the future of public health. Evidence based public health would be a more secure foundation.

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1 Watkins SJ. For debate: public health 2020. *BMJ* 1994;309:1147-9. (29 October.)

2 Morrison I, Smith R. The future of medicine. *BMJ* 1994;309:1099-100. (29 October.)

Forget the old days of medical officers of health

EDITOR,—Stephen J Watkins advocates a return to public health paternalism, from which, thankfully, the specialty has begun to move in recent years.¹ Despite his assertion that public health doctors cannot work with "arbitrarily defined populations" in the same way as they can with "communities," the community that holds centre stage in the article is one based on the boundaries of local government—a clear example of boundaries that are not defined by the population within them.

More careful analysis of the text shows that this reflects the fact that the community that has centre place in Watkins's allegiance is a community not of ordinary residents but of bureaucrats. After all,

ordinary people would not be expected to regard local authority boundaries as marking their communities and would not consider their culture to be shaped by the "common media" of council affairs. Watkins's community is one of local institutions. While this is undeniably important in influencing health at a local level, these institutions should not be confused with the people who live within the boundary of the local authority: to do so reinforces bureaucratic paternalism, in which bureaucrats look after the population.

One of the great advances in public health in recent years has been the growing recognition that people who live in districts and boroughs have a right to have their views heard by bureaucrats in the health service. This has been coupled with an ethos that encourages people to take more responsibility for their own health. In the light of this, Watkins's image of the doctor "responsible for . . . a community," which itself is eagerly listening for advice on action it can take to improve its health, is a retrograde one. Our challenge for the 1990s should rather be to devise ways of turning the rhetoric of involving and listening to local people into a reality, while avoiding the minefield of "community" ideology.

Watkins's assertion that public health is multi-disciplinary is brought into question by the emphasis in the article on public health doctors and nurses (the doctors' handmaidens?). This vision of the future is all the more remarkable given that the Faculty of Public Health Medicine is currently looking to open its door more widely to non-medical members, who it seems to expect will be largely people with backgrounds in the social sciences, health economics, statistics, and management.

Though I do not wish to be associated with the rampant managerialism that has become a feature of parts of our specialty in recent years, it does public health a disservice to harp back continually to the old days of medical officers of health. It is time for the specialty to look forward, to push aside the curtains of ideology, and to determine what our role really is in these turbulent and uncertain times.

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Eradicating gonorrhoea

No "epidemiological" treatment

EDITOR,—I take issue with Chris Bignell's recommendation that treatment for gonorrhoea should routinely be combined with treatment effective against *Chlamydia trachomatis*.¹ This amounts to epidemiological treatment of chlamydia infection, by which I mean prescribing antibiotics either without doing microbiological investigations or before the results of investigations are known.

It is common American practice to use epidemiological treatment.² British genitourinary medicine, however, condemns epidemiological treatment on the grounds that potent antimicrobials (which may have side effects³) are used without a clear indication. Not all patients with gonorrhoea are also infected with chlamydia.⁴ Sensitive and specific tests for chlamydia exist,⁵ and drugs that are effective against chlamydia should not be used unless *C trachomatis* has been shown to be present.

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More is needed than just treatment

EDITOR,—It is possible to eradicate endemic gonorrhoea from Britain, as Chris Bignell states.¹ In addition to effective treatment, however, other, equally important factors, including health education, effective contact tracing, and the cooperation of the public, are needed. When these factors are not optimum eradication of this disease may prove difficult. I report the experience at the department of genitourinary medicine at Middlesbrough General Hospital, the largest of three genitourinary medicine clinics in Cleveland.

In the six months May to October this year 10 patients (nine men, one woman) were diagnosed as having gonorrhoea. The age range was 17-52, and four patients had acquired the disease homosexually. Two men were asymptomatic; they attended the clinic for HIV tests only but agreed to be screened for sexually transmitted diseases. The female patient was also asymptomatic but was a partner of one of the men with the disease. Results of microscopy and culture showed a correlation for eight men; the remaining two patients were diagnosed on the basis of the results of culture only. One male patient had coincidental chlamydial infection. All the patients were treated with ciprofloxacin; results of tests for *Neisseria gonorrhoea* were negative in the eight patients who returned for follow up.

Contract tracing was successful for only three male patients. The reasons for failure in the six other cases were that two patients gave false names and false addresses; two had had no further contact with their partners; and two could not remember who their partners had been, giving alcohol as the reason for this amnesia.

The *Health of the Nation* sets the target of a 20% reduction in the incidence of gonorrhoea by 1995.² This department has seen a steady decline in the number of cases from a peak of 112 in 1990 to 27 in 1993. Health promotion campaigns and outreach workers have been active in recent years. Eradication of gonorrhoea is possible, but a lot of work is still to be done.

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Open access for screening is vital

EDITOR,—We wish to respond to Chris Bignell's editorial on gonorrhoea.¹ History has shown that gonorrhoea is difficult to eradicate but can be controlled at a low level. New remedies may inspire false confidence and attitudes towards this and other sexually transmitted diseases.² While effective gonococcal treatment is available, control must depend more on diagnostic methods, notification of partners, health education, and widespread screening, especially in areas of high prevalence. Even in areas of low prevalence, such as Stockholm, 57% of cases during 1987-9 were

considered to have been acquired endemically; this figure, however, was decreasing while imported cases remained constant.³ The short incubation period of *Neisseria gonorrhoeae* and asymptomatic infections will lead to the spread of imported cases into the indigenous population, so that endemic infection is maintained. Immunisation against gonococcal infection in the future may be possible but is hampered by the rapid antigenic variation of the organism.

Cases of gonorrhoea detected outside departments of genitourinary medicine may not be reported nationally and do not appear in the Department of Health's statistics. In one study patients seen by general practitioners accounted for a quarter of the cases of gonorrhoea. Only 54% were subsequently referred to the local genitourinary medicine department.⁴ This is relevant because the *Health of the Nation* uses gonorrhoea to indicate the sexual health of the nation.

Not all genitourinary physicians would agree with Bignell that gonococcal treatment should routinely be combined with effective treatment against *Chlamydia trachomatis*. If this policy was adopted then all partners should also be given epidemiological treatment for both organisms, which would lead to overtreatment.

Finally, to keep gonococcal infections under control it is vital to maintain an open access system of screening for sexually transmitted diseases and to ensure that all patients with gonococcal infection are referred to genitourinary medicine clinics.

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Initial management of suspected meningococcal infection

Parenteral benzylpenicillin is vital

EDITOR,—The seasonal upsurge in meningococcal infections is expected shortly. C S Nanayakkara and R Cox ask whether there is sufficient evidence to justify the chief medical officer's advice to general practitioners to give benzylpenicillin to patients with suspected meningococcal disease and whether there is a clear role for adjunctive steroid treatment in meningococcal disease.¹

A meta-analysis of recent trials has shown that dexamethasone given with or before the first dose of antibiotics in bacterial meningitis reduces the incidence of neurological or audiological sequelae.² There were too few patients with meningococcal meningitis, however, for any firm conclusions to be drawn on the value of steroids in this subgroup.

Patients with meningococcal meningitis but without septic shock have an excellent prognosis and a low rate of residual neurological deficits, which makes controlled trials of steroids difficult. Most infectious diseases units give dexamethasone to all children with turbid cerebrospinal fluid or with clear clinical signs of bacterial meningitis shortly before the first hospital dose of antibiotics. The pathophysiology in meningococcal and other types of bacterial meningitis is similar, and dexamethasone has reduced inflammation and residual