applications are likely to amount to a claim that a restriction on competition is justified because of offsetting benefits in other areas such as public safety." There will be an appeal against the decision of the new authority but only on points of law or whether the decision was justified by the evidence. No agreement will be exempt because it is too small, but those involving a turnover of less than £0.5m will be presumed to be not anticompetitive.

A whole range of ethical rules relating to medical practice that have been designed to protect the patient but which can be regarded as anticompetitive could become illegal. Both the BMA and GMC will face heavy fines unless they have removed them or obtained exemption from them from the new authority. They include rules restricting direct access to specialists, cooperation with alternative therapists and commercial arrangements, and sharing of premises with other professionals. Many of these restrictions are, however, enshrined in legislation such as the Cancer Act, and even the Monopolies Commission was prohibited from reporting on restrictive practices that had been conferred by statute within the past 10 years.

Doctors are different from other professionals in one important respect: it is not an offence to practise medicine as an unregistered practitioner, whereas it is to practice unregistered as a dentist or veterinary surgeon. But restrictions of certain rights to registered medical practitioners, most of them conferred by primary legislation, could be

regarded as anticompetitive—for example, those on prescribing controlled drugs, treating women in labour, and issuing death and cremation certificates, etc.

It is now 21 years since the BMA and GMC gave evidence to the Monopolies Commission. Our genuineness in claiming that our restrictive practices were in the best interests of patients was impressively illustrated by the rule that any employer who tries to insist that his employee doctors must be members of the BMA will find himself in the "important notice" in the *BMJ*. It will not be so easy this time. Views have changed since then—and not only with the change in government. The new generation has been subjected to a deluge of news on medical matters and believes itself better informed about them than used to be the case. It will be more difficult to justify anticompetitive practices because patients need to be protected against exploitation, as was clearly shown by the reception given to the BMA's report on alternative medicine a few years ago.

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- 1 Department of Trade and Industry. *Review of restrictive trade practices policy. A consultative document*. London: HMSO, 1988. (Cmnd 331.)
- 2 Monopolies Commission. *Professional services*. London: HMSO, 1970. (Cmnd 4463-1.)
- 3 British Medical Association. *Annual report of council 1967-8*. London: British Medical Association, 1968:38-43.
- 4 Fletcher A. Parliamentary written answer. *House of Commons Official Report (Hansard)* 1985 July 23;83:cols 450-1. (No 1640.)
- 5 Office of Fair Trading. *Advertising by the professions: a review of the remaining significant restrictions*. London: Office of Fair Trading, 1986.

Death despite malaria prophylaxis

Over 80% of infections with *Plasmodium falciparum* imported into Britain between 1977 and 1986 were acquired in Africa,¹ and virtually all patients presented within two months of their return.

One patient was a 25 year old man who had spent his honeymoon in the coastal resort of Malindi, Kenya. On his doctor's advice he had taken chloroquine and proguanil while in Kenya and was still taking both two weeks after his return to Britain, when he consulted his general practitioner because of fever. His only other symptom was headache, but his astute general practitioner realised that despite prophylaxis malaria was possible. He prescribed a therapeutic course of chloroquine, which the patient started immediately. After initial improvement the patient suddenly deteriorated, and his general practitioner was alarmed to find him slightly confused two days after starting treatment. The patient was taken to hospital immediately but was dead on arrival. He had assiduously followed medical advice and the general practitioner had made the correct diagnosis. Nevertheless, both prophylaxis and cure failed, and we must ask whether either could have been improved.

Would a different prophylactic regimen have made a breakthrough infection less likely? Recently Danish workers reported no significant difference in the rate of breakthrough infections in travellers taking chloroquine combined with either Fansidar (pyrimethamine 25 mg, sulfadoxine 500 mg) or proguanil (19 March, p 820). Their findings support the consensus that chloroquine and proguanil represent the best balance between safety and efficacy for malarial prophylaxis in areas where chloroquine resistant *falciparum* malaria has

been reported. This is therefore the regimen of choice for visitors to any part of tropical Africa, and they should be made aware that no form of prophylaxis will infallibly prevent malaria.

Diagnosing or excluding *falciparum* malaria must be the priority in any febrile patient with an appropriate travel history regardless of whether chemoprophylaxis was taken. In practice, confident exclusion of the diagnosis is difficult: although malarial parasites are usually found in more than 1% of red cells in patients with *falciparum* malaria, it is not rare for peripheral blood to contain so few parasites that none are found in a blood film. Thrombocytopenia is almost always found in patients with *falciparum* malaria and is an argument for empirical treatment.

The choice of treatment is crucial. All patients who have been taking a prophylactic regimen that includes chloroquine must be treated with quinine however mild their illness because a breakthrough infection is almost certain to be caused by a resistant strain. In practice therefore chloroquine should be abandoned in treating *falciparum* malaria, and all general hospitals should stock both oral and parenteral quinine.

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