general practice in the United Kingdom. Called, imaginatively, GP-UK, the list is run by collaboration between the Sowerby Unit for Primary Care Informatics at Newcastle University and the Primary Health Care Specialist Group of the British Computer Society. GP-UK deals with topics such as clinical research and medical informatics, with specific reference to British general practice. Within its first six months it has over 150 members. Views from outside the United Kingdom are also welcome, and, indeed, the list includes members from Europe, Australia, and the United States. To join simply send an email message containing the following command to mailbase@mailbase.ac.uk:

```
join gp-uk <firstname> <surname>
stop
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A few words of caution may be appropriate amid the euphoria, however. As interest and traffic increases, discussion lists are in danger of becoming swamped: the bulk of information becomes too daunting for regular readers, who then cease to contribute. In response, list owners may become in reality editors, producing a regular digest of important contributions, or the list may have to be divided into daughter lists covering specialist subjects.

This all requires human and financial resources. We are grateful to Mailbase for its support, but this can be maintained only for as long as the list is perceived to be academic rather than clinical. As interest broadens and deepens additional resources will be required.

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Helping health services in the developing world

EDITOR,—Michael Harper outlines an excellent example of a mutually beneficial relationship between general practice in Britain and a community health scheme in rural India.¹ We too are engaged in giving help to the health services in part of the developing world. Current development theory equates sustainable development with economic self sufficiency. Our experience, like Harper's, is that it is more a question of "holistic interchange." With the meagre resources available to the health service in a country such as Nepal, insisting on economic self sufficiency is equivalent to doing nothing (or, at least, very little) while Rome burns. There is no realistic prospect of adequate government funding of the health service in this part of the world within the next several decades.

Western health centres should not allow concern about continuing financial burdens to prevent them from exploring the rich experiences, both personal and professional, available through contact with a southern health programme. Nor should general practitioners balk at helping

overseas district hospitals, which are often of equivalent scope to group practices, with similar problems and novel solutions—we are all engaged in primary health care.^{2,3}

Would that there was some kind of exchange for interested parties to make contact, as Whiteladies Healthshare Project has done. Social workers with their initiative are, alas, too rare. We would certainly welcome any interest in our work in the district general hospitals of this remote area of Nepal.

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Effects of drinking green tea

EDITOR,—The *BMJ* is regarded as one of the most important journals for original medical research in the United Kingdom and often acts as a source of information for the lay press. The fact that K Imai and K Nakachi's paper was accepted for publication reflects badly on the journal's peer review system.¹ The paper states that "green tea may act protectively against cardiovascular diseases and disorders of the liver." This is based on the observation that drinking more than 10 cups of green tea a day changes the mean alanine amino transferase concentration to 19.9 from 24.1 U/l in patients drinking less than three cups a day.

I would be interested in the evidence that an alanine amino transferase concentration of 19.9 U/l indicates a reduced risk of liver disease compared with a concentration of 24.1 U/l, both of which lie well within the normal range for this variable. We are also told that the cholesterol concentration was 4.58 mmol/l in the high consumers compared with 4.85 mmol/l in the low consumers and that this again represents a significant reduction in the cardiovascular risks. While this lowering may be statistically significant, I defy the *BMJ* to show evidence that it is of any clinical significance.

The *BMJ* has a responsibility to publish only well researched studies with valid conclusions. This paper shows that it is failing in that duty.

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- 1 Imai K, Nakachi K. Cross sectional study of effects of drinking green tea on cardiovascular and liver diseases. *BMJ* 1995;310:693-6. (18 March.)

CD4 cell counts used as surrogate test for HIV infection

EDITOR,—The Haematological Malignancy Diagnostic Service in Leeds provides a diagnostic service for patients with suspected haematological malignancy in Yorkshire. Recently, we have become aware of increasing numbers of requests for CD4 cell counts. On further investigation we have found that in most instances these investigations have been requested as a surrogate for serological testing for HIV infection.

Knowledge of the CD4 cell count is useful only in monitoring the progression of disease in patients who are known to be infected with HIV. The count may be normal or decreased in HIV infection and in a wide range of other infective or immunological

conditions. If HIV infection is suspected the CD4 cell count is of no value in either confirming or excluding the diagnosis.

Explicit informed consent should be sought before an HIV test is performed, and facilities for counselling are made available to the patient should the result be positive. Some clinicians may consider that a request for a CD4 cell count circumvents the need for consent and counselling, especially in those in whom they have only a low index of suspicion of HIV infection. When they fail to request the definitive test such a suspicion may persist and be conveyed to other health professionals in contact with the patient. This may ultimately be detrimental to the delivery of effective health care to the patient. The confidentiality that patients suspected of having HIV infection have a right to expect may be compromised.

It has also been our experience that requests of this type rarely contain accurate clinical information, and samples are seldom labelled as a potential infection hazard. This constitutes a risk to a wide range of staff, including phlebotomists, medical laboratory assistants, and technologists.

We recommend that laboratory staff should always verify the reason why a clinician has requested a CD4 cell count. Samples sent from a surrogate HIV test should be discarded in the interests of good patient care and laboratory safety.

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General practice's last stand

EDITOR,—As the author of the discussion document from the BMA's General Medical Services Committee on core general medical services and the classification of activity by general practitioners,¹ I wish to respond to D P Kernick's attack on the document as "a milestone in our professional decline."² Kernick, who targets not only me but also the president of the BMA and the chairman of its council, portrays the discussion paper as futile, misconceived, anachronistic, and the product of a bunker mentality. While Kernick purports to have positive ideas about the future of general practice, the article seems to be singularly negative and lacking in faith.

The author's case seems to be that doctors should now no longer be paternalistic but should work in partnership with their patients; that the quality of care should be improved; and that general practitioners will increasingly have to develop business and managerial skills and a role in assessing need and in planning, managing, and delivering services accordingly. How Kernick conceives that I, the GMSC, or the discussion document espouses contrary views I cannot imagine.

Kernick's contention that "virtually all change has been imposed from without and almost universally characterised by professional antagonism" rewrites history with a vengeance. I would contend that the three greatest developments in general practice since the inception of the NHS have been the introduction of the Cameron contract in 1966, of mandatory vocational training in 1979, and of commissioning of care in 1991. The first two of these developments were the direct result of pressure from general practitioners, in which the GMSC took a leading role. Only the most recent development met with opposition from most general practitioners before its introduction, and, whatever the different attitudes to fundholding that remain, the commissioning role that is available to all practitioners as a result of the

purchaser-provider split in the health service is now almost universally welcomed.

Kernick also contends that doctors are being offered large handouts of cash to reward incompetence and encourage early retirement. No such scheme is now to be implemented, but the debate about how to address poor performance should be conducted in less pejorative terms.

The concept of the core content of general medical services, which Kernick reviles, has been developed because of the realisation that general practitioners' workload has been increasing,³ often without any additional remuneration and in the absence of any practical mechanism for them to identify, contract for, and secure remuneration for new services. Far from being a negative concept, it is intended to allow the roles of general practitioners and of primary health care to expand and develop, so long as the necessary resources to allow such development are provided. In attacking a strategy that is intended to deliver fair rewards to general practitioners in the future Kernick is out of touch with colleagues.

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- 1 General Medical Services Committee. *Core general medical services and the classification of general practitioner activity: a discussion paper*. London: GMS, 1994.
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Only a third of adverts for vocational trainees result in an appointment

EDITOR,—There has been much in the medical press lately concerning the falling popularity of vocational training for general practice. The practice in which I work advertised in the issue of the *BMJ* published on 4 February for a trainee to start in August. There was little interest, so six weeks after the advertisement appeared I wrote to all the other practices that had advertised in that issue to determine their experiences.

I sent out a letter with a questionnaire printed on the reverse, and I enclosed a stamped addressed envelope to encourage replies. Practices were asked the number of inquiries that had resulted from the advertisement, the number of applications that had resulted from the advertisement, whether a trainee had been appointed, and if applicable, whether the appointment had been a result of the advertisement. Comments were also invited. Practices that were in the process of appointing someone were contacted six weeks after their initial reply to gain an accurate record of events.

Forty six practices were questioned, and 43 replied (response rate 93%). Twenty two practices had had no inquiries, 26 had had no applications, and 29 had failed to appoint a trainee (table).

The results do much to confirm fears about recruitment of trainees in general practice, and the high response rate may show a measure of concern

Distribution of inquiries about, and applicants for, 43 posts for vocational trainees in general practice advertised in "BMJ," and number of appointments made. Figures are numbers of practices

	No of inquiries/applicants			
	0	1	2	3
Inquiries	22	13	6	2
Applicants	26	11	6	
Appointment made	No	Yes		
	29	14		

over this issue. Perhaps the most interesting information came from the comments added by almost every respondent, some of whom wrote accompanying letters. Many expressed concern for the future of general practice, some fearing that the situation reflects a perception of low morale dating from the introduction of the new contract in 1990. There was a suggestion that newly qualified doctors previously keen on a career in general practice are taking time out until "new general practice is sorted out." Two practices were to have no trainee for the first time in 10 and 14 years, while another, having advertised unsuccessfully in the *BMJ* twice, eventually received applications through a European journal.

Whatever the reasons, this simple survey provides objective evidence of an impending dearth of vocationally trained general practitioners, which requires urgent attention.

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NHS medical card

Still sexist after all these years

EDITOR,—On receiving my new NHS card I was puzzled to see printed on the front of the envelope the statement that, should I require a home visit, I should "help my doctor by asking him before 10 am." My current doctor is female, as was my previous doctor. I am told by the BMA that almost one third of all general practitioners in Britain are female, and I understand that the proportion of new medical students who are female is even higher.

The appearance of biased assumptions like this on official NHS correspondence is outdated (the first female doctor in Britain began practising in 1870) if not dismissive of the existence and value of female doctors. Is a small printing correction—perhaps when stocks are renewed—too much to ask of the NHS in carrying out its equal opportunities policy?

Some might call this nitpicking; others might see it as a slight, and welcome, correction on the path to true equality.

PAIGE SINKLER

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NHS Executive's reply

EDITOR,—We try to ensure that any such wording is amended, but this particular form seems to have been overlooked. I shall ensure that the form of words is amended at the next reprint, and I apologise to Paige Sinkler for any offence caused.

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Pacific nuclear tests should not go ahead

EDITOR,—On behalf of the Medical Action for Global Security (MEDACT), I am writing in support of the protest by Australian doctors over French nuclear testing.¹ No relevant official medical data exist owing to the secrecy that has shrouded past tests, but it seems likely that outbreaks and the rise in incidence of ciguatera, which is widespread in the Pacific, arise from nuclear testing together with the activities needed for the supporting infrastructure.²

The geology of the two atolls that have been used

renders them unsuitable as repositories of highly radioactive waste, for reasons such as their tendency to natural fissuring. Caesium-134 has been found in samples of water obtained locally and, with a high degree of probability, in plankton obtained 19-22 km downstream from Mururoa.³ This suggests strongly that radioactive material is already seeping from the test sites, with the risk that it will enter the food chain.

MEDACT shares the Australian doctors' hope that the French government will take note of the widespread concern over the tests and abandon them. It will be contributing to the Australian doctors' advertisements in the French press; any doctor wishing to be associated with this is asked to contact MEDACT's office.

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Misleading drug packaging

EDITOR,—There is always scope for dangerous errors to occur when drugs are given, especially if they are injected.¹ To ensure that the correct drug is given, one school of thought argues that ampoules of drugs should be distinguishable only by the writing on their labels and not by any other characteristic such as shape or colour.² The opposing view states that ampoules should have a distinctive appearance and should be colour coded so that products look as different as possible.³

The worst possible scenario is happening: some manufacturers supply their different products in distinctive forms, while others catch out the unwary by supplying different products in containers that are identical except for the lettering. The lettering in the example in the figure is 1.5 mm high and is difficult for someone with modest presbyopia to read. If the person giving the drug is unaware of the existence of a similarly packaged preparation the patient may be put at risk.

Labels (for two different products) which are identical apart from lettering

Distributing medicines in standard ampoules of standard format can work only if the system is adopted widely. Otherwise we should encourage diversity: it could make the difference between life and death.

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