Special Groups in Tuberculosis

SIR,—The letter from Dr. J. R. Lauckner and others (27 March, p. 727) contains the following statement: "We recognize that tuberculous disease in this country (as in other developed countries) has been declining for the past 50 years at least, and will continue to decline in future, *irrespective of anything which the medical services have done or can do*" (my italics). This statement is followed by a reference to a report by Drs. Styblo and Meijer and myself[1], implying that this statement, and in particular its final clauses, represents our conclusions.

I wish to make it clear that our report deals entirely with tuberculosis in the Netherlands, and that we are careful not to extrapolate the findings to this or any other country. Moreover, no words remotely resembling those in italics, nor any similar denigration of the role of the medical services, occur anywhere in the report. Dr. Lauckner and his colleagues must accept the full responsibility for this extravagant claim themselves.—I am, etc.,

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[1] Styblo, K., Meijer, J., and Sutherland, I., *Bulletin of the International Union Against Tuberculosis*, 1969, **42**, 5.

Septic Gonococcal Dermatitis

SIR,—Drs. J. Barr and D. Danielsson provide an excellent review of the dermatological manifestations of gonococcal septicaemia in Orebro during a 20-month period. The article reflects Scandinavian interest in this condition over the past 10 years.[1 2]

It is important to remember, however, that there is a wide spectrum of clinical presentation of this septicaemia,[3-5] and that in their series the predominant clinical features were the pyrexia and the cutaneous lesions while the locomotor involvement was of lesser importance. In our own series (submitted for publication) we report patients from our Belfast clinic in whom the dominant clinical manifestation was polyarthropathy with pyogenic effusions and associated tenosynovitis, and in whom skin lesions were either absent or very limited in extent.—We are, etc.,

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[1] Kvorning, S. A., *Danish Medical Bulletin*, 1963, **10**, 188.
[2] Bjvrnberg, A., and Gisslfn, H., *Nordisk Medicin*, 1965, **73**, 338.
[3] Vietzke, W. M., *Archives of Internal Medicine*, 1966, **117**, 270.
[4] Taylor, H. A., Bradford, S. A., and Patterson, S. P., *Obstetrics and Gynecology*, 1966, **27**, 776.
[5] Branch, G., and Paxton, R., *Public Health Reports*, 1965, **80**, 347.

Rheumatoid Neuropathy

SIR,—May I be allowed to comment on your interesting and helpful leading article on rheumatoid neuropathy (6 March, p. 516).

In my experience the severe sensory motor disease may start as a mixture of mononeuritis multiplex and sensory neuropathy, not just as mononeuritis multiplex as stated in the article.

In my opinion steroids in large dosage are responsible for the severe type of rheumatoid neuropathy. I am seeing far fewer cases of rheumatoid neuropathy than I did ten or eleven years ago. After most careful consideration I feel that the only different factor between now and then is that steroids are now used in much lower dosage.

Unfortunately, I agree that the treatment of neuropathy is unsatisfactory.—I am, etc.,

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SIR,—In your leading article on "Rheumatoid Neuropathy" (6 March, p. 516) it is stated that there is no known effective treatment for the severe sensory motor variety of the disorder. While this is essentially true, two important points are perhaps worthy of mention in this context.

When a patient with rheumatoid neuropathy is on steroids it is unwise to attempt to lower the dosage on the grounds that steroids might have predisposed to the neuropathy. Such patients often have widespread arteritis, which is to some extent suppressed by steroids and which can become "active" when they are reduced, with disastrous results such as intestinal infarction due to mesenteric arteritis.

The other matter is the possible role that immunosuppressive agents, such as cyclophosphamide and azathiaprine, and (perhaps particularly) D-penicillamine might play in the treatment of rheumatoid neuropathy. Whereas the results of a controlled trial (currently in progress) are not yet to hand, Jaffé[1] has shown that D-penicillamine therapy can lead to improvement in some cases of motor neuropathy. I have a patient with severe rheumatoid arthritis who presented with bilateral foot-drop and paraesthesiae of the feet in March 1967. Motor conduction velocity was reduced in the lateral popliteal nerves. Within six weeks of starting therapy with D-penicillamine, 900 mg daily, the degree of foot-drop lessened, and some voluntary movement returned to the feet. There was concurrent fall in the E.S.R. and in the serum gamma globulin. To date, this patient is alive and well and still taking the drug.—I am, etc.,

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[1] Jaffe, I. A., *Arthritis and Rheumatism*, 1970, **13**, 436.

A Case of Confidence

SIR,—Your leading article "A Case of Confidence" and the correspondence (20 March, pp. 620 and 668) are disappointing and leave confusion worse confounded. Certainly, a doctor has an obligation to act in the way he judges to be in the best interests of his patient, but surely unless the patient is a child or of unsound mind the doctor must also act with the patient's consent, explicit or implied. Certainly in treating a young child the doctor has an ethical, and presumably a legal, duty to inform the parent or guardian of the treatment he proposes to give. But at what age does this obligation cease? Is it tied to the right to consent to treatment, which is granted to the child at 16 years, or is it connected with the parents' duty to give care and protection, a duty which continues until 18 years? Dr. Leahy Taylor (p. 668) considers the Family Law Reform Act (1969) irrelevant to the obligation of secrecy. If, indeed, a 16-year-old has no absolute right to confidentiality perhaps the clinic doctor still has a duty to inform the parents. If not, why not? After all, a court can commit a young person to care if the parents fail to protect her from moral danger. Hence, a doctor who gives contraceptive treatment or advice to a girl of 16 years without the parents' knowledge is usurping their duty to safeguard her moral welfare. In fact, I believe that Dr. Leahy Taylor's statement is incorrect, but we all need to know where we now stand.

Indeed, is confidentiality as absolute as Dr. M. H. Pappworth (p. 668) would make it? He will not divulge the secrets of his patients unless compelled by judge or statute, but he omits to say how he treats the secrets of children of 15-years-old, the disclosures of the epileptic driver, the mother who confesses to battering her baby, or the heroin addict who betrays his source of supply. He does not tell us that, in general practice, he would deny other members of the health team—nurses, health visitors, perhaps social workers—access to his medical records or forbid them to take information to co-ordination committees where problem patients might be discussed, without their knowledge, with other social workers, housing officers, probation officers, or school attendance officers. Yet these problems, the issues raised by the Browne case, and concern over the medical use of computers have all undermined the once clear principles of medical confidentiality.

When an honest, sincere doctor who has struggled with his conscience finds himself before the General Medical Council there is evidence of a deeper malaise, a general conflict in society, not only between the rights of the individual and the pressures of efficient organization but also between traditional and permissive attitudes.

Those of us who work with people cannot be immune from these conflicts and it is high time the British Medical Association undertook a thorough examination of the problems of confidentiality in all its aspects to give guidance to everyone.—I am, etc.,

DAVID L. WILLIAMS

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SIR,—There comes a time in every worm's life when it has to turn. The worm on this occasion is the general practitioner, who is sick of being told by all forms of communication that he should encourage and condone children in indulging themselves in sexual intercourse. To give the pill to unmarried teenagers is to allow the self-indulgent, the wilful, and the thoroughly spoiled to become even more so. I am sure every general practitioner would agree that the sort of girl involved in the Browne case is no example. As for those who tell us we should give the pill in order that pregnancies may be avoided, they should look at the figures showing the rising rate in venereal disease.

There is only one way to avoid the serious outcomes of promiscuous intercourse—pregnancy and disease—and that is for the participants to have the self-control to keep (as it seems to be the fashion) their trousers on. —I am, etc.,

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