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Tuberculosis: who should prescribe?

The welcome decline in the number of patients suffering from tuberculosis in many countries, including Britain, has made experience in the diagnosis and management of the disease more difficult to obtain. Newly graduated doctors may have seen little or no tuberculous disease during their undergraduate years. A recent study in North America showed that there were prescription errors in over half the cases treated by recently qualified non-respiratory physicians, with the blame being placed (in part) on inadequacies in medical school curricula.¹

The *BMJ* has recently published three retrospective accounts of the routine clinical treatment of tuberculosis, one dealing with pulmonary² and two with non-pulmonary disease.^{3,4} Wardman *et al* specifically identified therapeutic errors in 10 patients, all of whom began inappropriate chemotherapy given by non-respiratory physicians.³ In two patients the errors made were gross; one died later from extensive renal tuberculosis, and the other relapsed six years later with cryptic miliary tuberculosis. A third patient suffered from severe peripheral neuropathy as a result of an excessive dose of isoniazid given during six weeks' treatment. The remaining seven patients were apparently cured despite the fact that only one received a regimen acceptable in type and duration. Isoniazid was sometimes given in divided doses, excessive doses, or inadequate doses; rifampicin was given in too low a dose or the timing of administration of the drug was incorrect; and ethambutol and streptomycin were given in divided doses. The authors concluded that "there is a strong argument for all cases of tuberculosis to be referred to a respiratory physician for chemotherapeutic management from the outset." Woodroffe has disputed this conclusion, arguing that the problem is not one of lack of special knowledge but failure to look up the proper dose of the drug(s) being prescribed.⁵

The problem of who should treat tuberculosis is not as clear cut as either Woodroffe⁵ or Wardman *et al*³ suggest. The treatment of tuberculosis is a question not only of drugs and dosage, but very importantly of regimens and the duration of treatment. Accurate information on the doses and toxicity of antituberculous drugs is given in the *British National Formulary*,⁶ yet the drugs may still be prescribed wrongly if the introductory paragraphs (which give clear instructions regarding one appropriate regimen) are missed.

With the decline in the prevalence of tuberculosis in many countries family doctors and many hospital clinicians may be called on to treat one or two or even fewer patients in a year. The occasional prescriber would therefore be well advised to seek the advice of the chest physician—who may be as vulnerable to error as any other clinician but is familiar with effective regimens in varying circumstances and with the

minutiae of drug toxicity. Such knowledge is necessary to ensure total success in compliant patients.

As McLarty has pointed out, however, in large areas of the world specialist physicians are few and far between.⁷ Errors of treatment are rarely seen in these areas—because a simple standardised treatment course is used. Perhaps there is a message there for the developed countries.

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Legislation and medical ethics

One of the most difficult dilemmas in medical ethics is the apparent conflict between the principles of confidentiality and public safety. In Britain the medical profession has been fortunate in that, until now, Parliament has been very reluctant to enact legislation that would compel doctors to disclose information without the consent of the patient. In exercising their power of subpoena, whether of medical records or of a doctor as a witness, the courts are always ready to listen to objections and explanations from a doctor about why a particular piece of evidence should not be disclosed, and judges will often uphold the doctor's objection and refuse to order him to disclose that evidence.

There is no substitute in clinical medicine for careful history taking, and the notes of the patient's previous attendances, investigations, and treatment are essential for decisions. The knowledge that this information will be disclosed only in the most exceptional circumstances ensures that patients are entirely frank and that doctors keep comprehensive notes. Any relaxation of the traditional safeguards would change these attitudes and create the risk of patients being treated on the basis of incomplete or inaccurate information. That risk explains why the medical profession must examine very closely two Bills recently presented by the Government to Parliament.

The first is the Police and Criminal Evidence Bill,¹ which is proceeding rapidly through the House of Commons. Clause 10 provides that a circuit judge can issue an order requiring the production of evidence to the police, and in certain circumstances he may issue a warrant to search for it in the case of arrestable offences. A doctor will be given no opportunity, as he has at present, to object to the disclosure of medical records,

and there is nothing to stop the police keeping all the information obtained for as long as they like or for using it for other purposes.

This pernicious provision first appeared in an attenuated form as a recommendation of the Royal Commission on Criminal Procedure,² later to appear in a more objectionable form in the Government's discussion paper (which provoked the BMA to send a deputation to the Home Office). Now it has appeared in still more blatant and intolerable form as a clause in the new Bill.

The other cause for concern is the Data Protection Bill,³ published on 22 December, which (the Government claims) will enable the United Kingdom to ratify the European Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data.⁴ There is a long history behind this Bill, beginning with the Younger Committee on Privacy⁵ and continuing with the Lindop Committee,⁶ and with the present Government's White Paper. We have referred in the past to the BMA's active participation in this important issue, and the results of the BMA's representations have been rather more effective than in the events leading up to the Police and Criminal Evidence Bill. The Data Protection Bill, however, is a grave disappointment to anyone concerned with the principles of privacy and their common sense application in medical practice. The Bill applies only to computerised records, and more than 95% of medical records are still held in manual systems. The most important amendment to be obtained in this Bill is the extension of its provisions to manual

records. There are many other omissions or unsatisfactory provisions in the Bill relating to codes of practice, the duties and powers of the registrar, the advisory committee, and the sanctions for breach of confidentiality. Regulations relating to health matters will be made by the Home Secretary, who is required only to consult with the registrar. Why is the Department of Health and Social Security not to be concerned?

The almost simultaneous appearance of these two Bills, mutually inconsistent as they are, constitutes a formidable threat to the future confidentiality of medical records. We hope that the public reaction, communicated through members of Parliament, will succeed where the representations of the medical profession, on behalf of the patient, have failed so far.

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¹ House of Commons. *Police and Criminal Evidence Bill*. London: HMSO, 1982.

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³ House of Lords. *Data Protection Bill*. London: HMSO, 1982.

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Regular Review

Failure patterns after total hip replacement

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In May 1961 John Charnley described the initial favourable results of 97 total hip replacements using a new low-friction arthroplasty which he had developed with the encouragement of Sir Harry Platt and the advice of engineers at Manchester University.¹ Charnley had been stimulated by a chance encounter with a patient who had had a Judet femoral head replacement for osteoarthritis which emitted an audible squeak in certain positions. His development of a low-friction arthroplasty and its early success followed the application of basic engineering principles to prosthetic joint design; this convergence of disciplines, on the one hand the engineer and on the other the orthopaedic surgeon, was then—and remains—one of the most important associations affecting the outcome of joint-replacement surgery.

Research may some day make replacement in rheumatoid arthritis unnecessary, but in degenerative osteoarthritis of the hip nothing seems likely ever to compete with total joint replacement for the speed of recovery and quality of the early result. This comparatively new surgical procedure is therefore

here to stay, so we must look carefully at ways in which patients fail to benefit from what is a major operation. The aim of total hip replacement surgery is to relieve pain arising from the joint as a bonus to relief of pain the range of motion of the joint increases and walking improves. Failure to achieve this primary aim of a pain-free joint is classed as a failure for that patient. Müller (who after Charnley has the longest experience of total hip replacement surgery) reported in 1970 a failure rate of 1% a year and expected a failure of 10% after 10 years.² At that time he advised total hip replacement only as a last resort for patients under the age of 60—when intertrochanteric osteotomy was not possible. Now, however, with improved prosthetic design, and as surgeons become more familiar with techniques of total hip replacement, low-friction arthroplasty is being offered throughout the developed world as the primary surgical treatment for painful disabling hip arthropathy with less regard for the patient's age.

I shall now try to identify certain patterns of failure that occur after total hip replacement.