would in most cases need more capacity. On the district side the scope for putting a whole block of work elsewhere is limited. Costs and capacity would limit the ability of the hospitals in neighbouring districts to take on more work, and simply transferring a few cases would make the losing hospital more inefficient because the costs per case would rise. No one was very clear about the mechanism of making a large investment in extra capacity, particularly at a time of squeezed budgets: "How do you get agreement with a purchasing authority on a 30% increase in services?" said one doctor.

Another lurking fear stems from the knowledge that a system based on contracts is much more volatile than the old system: there is a real danger of things falling apart. Several people had taken part in East Anglian's Rubber Windmill exercise, a three day simulation of the internal market over three years, and were chastened by its lessons. The main ones were that if there was strong competition within fixed budgets quality soon went by the board in a scramble for quantity. Another lesson was that GP fundholders could cause enormous problems within the system as a whole and that "ways need to be found to hold them accountable for health and quality outcome objectives."¹

Quality

There are plenty of clauses on quality in the West Suffolk contracts, but the hospital contracting team sees them more as getting quality on the agenda than as definite targets. Most are still fairly soft, concerning information for patients and making sure that people don't wait too long in outpatient clinics. The community unit already has a quality assurance scheme, and the hospital is busy doing surveys of patient satisfaction, but the district is perhaps the most

aggressive in pursuit of quality. It cannot demand different quality standards for West Suffolk patients from those provided for the home purchaser, but it has demanded the right to make inspections—two pre-arranged and two unannounced—to ensure that each unit is meeting its own quality standards. The home units are quite happy about this, but the requirement has apparently been met with some derision in other units.

Beyond 1991: towards the rubber windmill?

One thing quickly becomes apparent in West Suffolk—that the old NHS worked well. Doctors and managers are already doing many of the things the reforms are meant to encourage. The doctors therefore don't really see the need for the changes, but they do see the risks. The gloomiest view, reinforced by the rubber windmill experience, is that everything will collapse because the upheaval is just too great. "It's like getting dressed on a helter skelter," said John Bracegirdle, orthopaedic surgeon and chairman of the medical staff committee.

On the other hand, people are thinking innovatively about the future, and some are honest enough to admit that the prospect of competition might have sharpened their thinking. "I would like to think," said one of the pathologists, "that it is not just threats of competition that are making us think harder about the way we receive specimens and transmit the results back to clinicians." Likewise, Mrs Deakin in the community unit would like to think that she would anyway have been thinking as hard about providing responsive community services as she obviously is—but the question remains in the air.

¹ Chatfield P, Kemp P, McIvor J, et al. *Beyond the windmill: lessons from the marketplace*. Cambridge: East Anglian Regional Health Authority, 1990.

Letter from Brasília

Semiologia

P D Marsden

This morning we are going to teach a physical signs class together, at least that is what they called it in England. Here in Brasília it is distinguished by the name semiologia and is one of our highest credited compulsory courses. How can it be otherwise, especially in the tropics? With experience a good history and careful clinical examination will usually show the probable diagnosis. The undergraduate takes many years to learn the discipline. These students have been prejudiced by a recent hospital strike, which is why I have offered to take a class as I have taught the subject on four continents.

The students are waiting in front of the ward. I line them up. They seem to be clean, well groomed, and dressed in white according to the hospital rule. I request that all hand rings and bracelets are removed since there is good evidence that they harbour staphylococci and these are easily transmitted in a tropical climate. Since our patient has a heart condition I ask the students to put their stethoscopes round their necks. Some of them seem to have suitcases full of medical instruments—they are that keen. The stethoscopes are

too long and I explain how to cut down dead air space. They know about Lannaec but not his stethoscope, which I illustrate. Then I explain how to behave at the patient's bedside, recalling a student being sent out of the ward at University College Hospital, London, because he sat down on a ward round—a mark of gross disrespect to the patient. I explain that the most difficult things in clinical examination are observation and concentration. The mind should be focussed solely on the patient and his or her problem. Then we file in.

Our patient is a 17 year old girl to whom I had spoken the night before. One student is chosen to elicit a history of symptoms related to the relevant system. He begins well with name, age, occupation, and where she comes from—the last an important point since Brazil has many different patterns of disease. The patient has never seen in her home the triatomine bugs that transmit Chagas' disease. She complains of paroxysmal dyspnoea and palpitations. After much discussion about important aspects of the history we come to the physical examination.

Núcleo de Medicina
Tropical, Universidade de
Brasília-CP 153121, 70.010
Brasília D F, Brazil
P D Marsden, MD, professor

I ask a different student to take the pulse. This is done well and he detects a rather small volume but omits to feel the opposite radial pulse. We discuss causes of an absent radial pulse including anatomical variations. A colleague then confirms the blood pressure of a small pulse as 110/80 mm Hg. The students then make the mistake of wanting to examine the precordium—how those stethoscopes upset them. No, the next thing is the neck and I talk about James Parkinson as I arrange the pillows at 45° and get the patient's neck in a good light. There they are, both the venous pulse and the transmitted arterial pulse in the line of the carotid sheath at the anterior border of sternomastoid. She has about 2 cm of jugular congestion and this is confirmed by the hepatojugular reflux, although she has no other signs of congestive heart failure. There are no abnormalities of the venous waves.

Juniors' universal fear

Now we get to the precordium and a student steps forward who has been taught by me in the outpatient department. She spends a long time looking at the precordium, too long, but that's the fear of doing something wrong, the same fear that is responsible for hospital junior staff worldwide ordering a legion of unnecessary investigations which overstrain the laboratory. She gets it. The patient has a visible parasternal heave of right ventricular hypertrophy. We raise the left breast and she has a visible forceful apex beat outside the midclavicular line in the fifth intercostal space. The student measures the distance. Now another colleague does the palpation but doesn't detect the diastolic thrill that I can feel at the apex. I position the patient on her left side so that they can feel it. I do the percussion because that bit is still difficult for them.

Finally, we get to Lannae's famous instrument. One of the last students is chosen for the auscultation but his technique is unsatisfactory, again the result of inexperience. Our patient has two apical murmurs, the low rumbling diastolic murmur of mitral stenosis responsible for the thrill and the pansystolic murmur of mitral regurgitation. Sitting the patient forward, I can hear the systolic murmur clearly at the back so it's a good teaching position to differentiate and time the two murmurs. I illustrate the murmurs in an exercise book, ask each student to listen carefully at the apex and the area I have marked with a cross on the patient's back, and step out for a moment for a quick cafezinho—a tiny cup of Brazilian coffee.

I return to find the patient being examined by four students at once with the stethoscopes clapped on and

her pulses trapped. So out we go again to emphasise why the patient can't be treated in this manner. One at a time is the way, though it is true that there are many students. The ancient Greeks knew that the best teacher and student relationship is one to one. I explain that with the patient's permission they can come at another time and listen. Indeed, I want them to make at least three visits to try and fix the findings in their minds.

We go to see the x ray films and the electrocardiogram. The latter shows right ventricular hypertrophy. The chest x ray film shows a prominent pulmonary conus, an enlarged left ventricle, and a double shadow on the right side delineating the enlarged left auricle behind the shadow of the right. We return to the bedside to ask the patient about a past history of rheumatic fever. She gives a good history and took chemoprophylaxis for over a year.

Consultants rang the bell

Sitting outside the ward afterwards, one of the students asks me about my first course of physical signs. I reply how impressed I was with the discipline. The door of the ward was locked at 8.00 am when the junior and senior registrars, housemen, and students assembled. When the consultant came he rang the door bell and the sister came to tell him if he could do the round. She accompanied him at all times with the diagnostic trolley, instruments, and patients' notes. Before he saw anybody he would go and see the urine and faeces of his patients so as not to forget this important facet. After the round he would do the biopsy and endoscopy procedures and examine any material he wished to see in the ward laboratory. The discipline of clinical diagnosis has not changed much in my lifetime but the geographical distribution of disease has changed dramatically. I doubt if you could teach on such a patient in England today but you can do so in many parts of the tropics. Attempts are being made in many such countries to offer chemoprophylaxis for rheumatic fever patients. This is impossible in many parts of Africa, even where rheumatic heart disease is the commonest cardiologial presentation.

As we leave the ward I take them to greet a patient with Sydenham's chorea. We watch the involuntary movements from the end of the bed for a moment. I explain that this is another clinical manifestation of the rheumatic process and that I will be happy to receive their attempts to classify involuntary movements. An experienced clinical impression is valuable in such a patient—yet another example of the art of medicine.

ANY QUESTIONS

A woman in her 60s with chronic glomerular nephritis is being maintained satisfactorily on 2.5 mg prednisolone on alternate days. Is it safe for this treatment to be continued long term?

If it is true that the patient has a chronic and active glomerulonephritis then there is a risk of progressive renal failure, heavy proteinuria, hypertension, and fluid retention. If prednisolone 2.5 mg on alternate days was really holding her in remission then the dose should be continued as side effects should be non-existent. If she received a transplant maintenance prednisolone dose would be 5-7.5 mg every day.

"A diagnosis of chronic glomerulonephritis" could mean almost anything. If she has had a renal biopsy then a precise histological diagnosis (incorporating immuno-

peroxidase studies and sometimes electron microscopy) should have been made. Very few forms of primary glomerulonephritis respond to steroids. She might have a steroid sensitive nephrotic syndrome with a biopsy showing "minimal change" nephropathy, in which case she does not have "chronic glomerulonephritis." Other forms of chronic primary glomerulonephritis—for example, membranous, IgA disease, mesangiocapillary—do not respond to steroids. There are two systemic diseases which could lead to chronic glomerulonephritis and which respond to steroids—that is, systemic lupus erythematosus and polyarteritis.

It is unlikely that the steroids in this dose are playing any role in her disease—but if in doubt expert advice from the nephrologist who made the diagnosis should be sought. —GUY NEILD, *professor of nephrology, London*