trend. The number of elderly people and Asians has increased considerably in the past decade, and therefore great care needs to be exercised before an increased incidence of tuberculosis in England is predicted. Evidence in Birmingham points to a steadily decreasing rate, and we doctors need to ensure that it stays that way.

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1 Davies PDO. Tuberculosis is increasing in England and Wales. *BMJ* 1993;**307**:63. (3 July.)

Europeans may be more at risk

EDITOR,—P D O Davies expresses concern about a tendency to play down the apparent increase in tuberculosis in England and Wales.[1] Although there are local differences in incidence and not all health regions report appreciable changes, notifications in Britain increased by 5% in 1992 compared with 1991.[2] Isolates of *Mycobacterium tuberculosis* in Dudley during the four years 1989-92 increased by 48% compared with the preceding four years, 1985-8 (totals being 102 and 69 respectively). Only 20% of patients with the disease in developed countries are younger than 50[3]; in Dudley, however, 32 (30%) of 107 Europeans with tuberculosis were younger than 50.

Dudley has a largely urban population of some 304 000, of whom 95·5% are white Europeans. The number of isolates of *M tuberculosis* increased by 108% in Europeans aged between 15 and 60 and by 100% in Asians of Indian subcontinent origin in the same age group. The total population of Dudley increased between the censuses of 1981 and 1991 by 8% from 281 707 to 304 615. This change was largely due to an increase in the number of Europeans—from 184 499 to 202 787 in those aged 15 to 65 years and from 37 631 to 89 205 in those over 65. The number of Asians increased from 3890 to 9017 in those aged 15 to 65 and from 103 to 621 in those over 65.

Numbers of cases of tuberculosis in Dudley according to age and ethnic origin

	Asian (Indian subcontinent origin)		European	
Age (years)	1985-8	1989-92	1985-8	1989-92
<15		1	1	1
15-59	15	30	12	25
⩾60	8	5	31	37
Unknown			2	3
Total	23	36	46	66

Although laboratory investigations increased by 61% over the eight years studied, the number of positive cultures as a proportion of the total number of requests, 1·7%, did not change substantially (range 0·9 to 3·1%). Thirty nine of 107 European patients were under 60 (table). Only two infections occurred in European children under 15. In the 37 cases of Europeans aged between 15 and 60 the mean age was 37·5 years for men and 34·4 years for women. No case was related to HIV infection or an outbreak with a common source.

A recent report of tuberculosis in south east England showed a minor peak occurring in people aged between 20 and 30 and a more diffuse rise in elderly people.[4] Dudley's local figures may be too small to reflect important national trends, but they are disquieting and should reinforce determination to detect and control tuberculosis in the community.

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1 Davies PDO. Tuberculosis is increasing in England and Wales. *BMJ* 1993;**307**:63. (3 July.)
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Attempted suicide

Are affective disorders missed?

EDITOR,—The Danish follow up study of patients admitted after attempted suicide looked at an important health problem.[1] In view of the recognised risk of suicide in depression the low prevalence of affective disorder and the high prevalence of the category "no mental illness" are puzzling. Could this be a result of the well known underdiagnosis of affective disorders, especially in young people?[2,3] The editorial commenting on the study challenges the authors' views about the suitability of a high risk strategy for preventing suicide.[4]

It would be interesting to know whether an analysis comparing the patients who did and did not receive treatment (whether psychological, social, or with drugs) was or can be performed. If medical treatment reduced the suicide rate this would support its use as a preventive strategy. Studies like this one offer a rare opportunity to answer some basic questions about how a person at risk of taking his or her life should be dealt with.

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1 Nordentoft M, Breum L, Munck LK, Nordestgaard AG, Hunding A, Bjældager PAL. High mortality by natural and unnatural causes: a 10 year follow up study of patients admitted to a poisoning treatment centre after suicide attempts. *BMJ* 1993;**307**:1637-40. (19 June.)
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Authors' reply

EDITOR,—The diagnoses given in the study are those given in the record by the consulting psychiatrist after one or more consultations at the poisoning treatment centre. Some of the patients classified as not suffering from any mental illness may have had depressive illness that was not recognised at the consultation.

In univariate analysis of mortality from suicide the variable unwillingness to receive treatment raised the risk of dying of suicide (relative risk 1·99 (95% confidence interval 1·13 to 3·49)). In the multivariate analysis, however, this variable became non-significant. We considered the validity of information about willingness to receive treatment that was based on case records to be questionable, and we therefore omitted it from our final analysis. In the univariate analysis admission to a psychiatric department after discharge from the poisoning treatment centre was associated with a relative risk of later suicide of 1·40 (0·95 to 2·08). This variable was non-significant in both the univariate and the multivariate analysis.

We have permission to follow up the patients listed in the Danish psychiatric case register, which will give us more information about later suicide attempts, psychiatric treatment in the follow up period, and changes in diagnoses. Analyses of these data have not been completed.

Gethin Morgan's editorial challenged our view about the suitability of a high risk strategy. We agree that special attention should be paid to treating people who attempt suicide who fulfil criteria indicating that they are at high risk of later suicide. We pointed out, however, that people who attempt suicide but who do not fulfil such criteria are also at risk.

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Primary care and public health

Have a lot in common

EDITOR,—We welcome David R Hannay's call for primary care and public health medicine to work more closely together to provide effective health care.[1] Their roles are complementary: general practitioners are advocates for individual people and public health physicians are advocates for populations. This difference in emphasis can be a strength provided both branches of the profession understand and respect each other's perspective.

We agree that general practitioners have had little training in population medicine. But public health doctors increasingly have backgrounds in general practice—for example, about half of the current trainees in Wales have either been principals or undergone vocational training for general practice. The Faculty of Public Health Medicine has a primary care group, which has already held several successful conferences. Membership of this group is open to general practitioners.

There are many examples of joint ventures, particularly in the development of morbidity systems for general practice. An example is the Welsh general practice morbidity database project. This is funded by the Welsh Office and aims to develop a method of extracting information on total morbidity from selected computerised practices in Wales. These data will be pooled centrally and then analysed. The information obtained will be used by both general practitioners and epidemiologists. The methods are expected to be developed by early next year.

The project has two broad aims. Firstly, it will provide practices with both information that has been analysed and comparisons with other participating practices. Secondly, the pooled data will provide baseline information for the health gain targets set under the "strategic intent and direction" for Wales. The project is therefore an example of primary care and public health medicine working together towards their common responsibility for preventing disease and promoting health. Most family health services authorities have developed links with their departments of public health medicine or have appointed public health physicians to provide advice. With more mergers between health authorities and family health services authorities these links will become even closer.

We note with disquiet the recent consultation document prepared jointly by the BMA's committee for medical advisers to family health services authorities and the Association of Primary Care Medical Advisers on the role and future career development of medical advisers. The creation

of a separate career structure and training programme for people who are essentially public health physicians, albeit with a strong background in general practice, seems a retrograde step.

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Integrated commissioning has brought them together

EDITOR,—As former general practitioners now practising as public health physicians, we endorse most of the views expressed in David R Hannay's editorial.[1] We do not agree entirely, however, with the suggestion that public health medicine pays insufficient attention to primary health care. Historically, the location of public health departments in district health authorities may have led to an emphasis in public health work on the then directly managed secondary care services. But the development of integrated commissioning through the fusion of district health authorities and family health services authorities, as has taken place throughout Wessex region, has brought primary care and public health together under one roof for the first time. We believe this to be a most important recent step, which is placing primary care issues near the top of health commissioners' agendas and should have warranted discussion in the editorial.

Hannay also fails to consider the role of family health services authorities' primary care medical advisers and the opportunities that they offer to bridge the gap between public health and primary care. A growing number of people appointed to these posts have been trained in both public health work and general practice, and they therefore embody the closer ties that Hannay calls for.

We do not believe, as the editorial suggests, that clinical contact is necessary for public health physicians to give credibility to epidemiology and health promotion. General practitioners argue that the increasing non-clinical demands of modern practice diminish clinical effectiveness; in the same way, clinical contact would compromise the public health physicians' skills and their focus on the population. There is an increasing mutual awareness between the two branches of the profession; this could be developed further by more input by public health medicine into general practitioners' training and by the recruitment to public health medicine of more general practitioners, whose clinical credibility has already been established.

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GPs can provide valuable data . . .

EDITOR,—Both general practitioners and public health doctors are key players in informing the commissioning process as well as having roles in health promotion.[1] Clearly, public health doctors should work closely with general practitioners on needs assessment locally by making much greater use of data on morbidity and mortality that general practitioners hold in their computers. General practitioners also have knowledge of the quality of care provided by provider units, and this information needs to be systematically extracted and used when contracts are placed and moved.

In Tower Hamlets the "partners in commissioning" project emphasises the close relationship between general practitioners and the health authority in purchasing matters. Because there are no fundholding general practitioners in the area all purchasing occurs through East London and City Health Authority, which in conjunction with its public health department can take an overview of needs in a particular locality. This and similar projects in other parts of Britain open the way for close collaborative working between general practitioners and public health doctors.

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. . . and they do

EDITOR,—I agree with David R Hannay about the confusion that exists over the roles of general practitioners and consultants in public health medicine but think that he is unduly pessimistic.[1] For example, general practitioners and consultants in public health medicine increasingly share data on sociodemographic issues, morbidity and mortality by practice, and issues emerging from the new banding arrangements for health promotion activity.

I dispute the view that the two branches of the profession are talking past each other, thus allowing managers to set the agenda. In my experience as a former director of public health in England and Wales during the past five years, the two branches are talking to each other more. The Griffiths reorganisation that established general management has enabled managers increasingly to set the agenda—for example, by appointing medical advisers to family health services authorities, under the terms and conditions of service for management staff, without involving public health doctors from the district health authority.

The joint appointments as medical advisers to district health authorities and family health services authorities of doctors with backgrounds in public health medicine and general practice are welcome: they are good for the health of the local population and for the two branches of the medical profession. These appointments, however, threaten management because of the false perception that medical professionals oppose change; there is a management view that only through the use of terms and conditions of service for management staff can medical professionals be "controlled."

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Careless terminology adds to confusion

EDITOR,—David R Hannay's editorial on primary care and public health contains several factual errors and confuses rather than illuminates the subject.[1] As someone with 10 years' experience as a general practitioner who is training in public health medicine, I wish to make some comments.

The editorial's title is "Primary care and public health," but the editorial discusses the role and values of general practitioners and public health physicians, which is not the same thing. General practitioners are the main, but not exclusive, providers of primary medical care. They are usually part of a multidisciplinary team that provides primary health care. Primary care, on the other hand, really refers to the point of first contact for a service that is typically locally accessible and does not require professional referral. In a similar way, public health is broader than the specific role of public health physicians.

Hannay refers to preventive services and health promotion having become more explicitly a core responsibility under the general practice contract. He specifically mentions immunisation and family planning and says that many general practitioners objected to the new contractual obligations because of lack of scientific evidence for them. Childhood immunisation and oral contraception are highly effective interventions and should not be confused with some of the more imaginative health promotion clinics that have been developed.

Hannay mentions the Acheson report of 1988, which followed an inquiry into the future development of the public health function.[2] He is wrong to say that the report recommended that the role of public health medicine is to set targets, allocate resources, and evaluate progress: these are the public health responsibilities of health authorities. The role of public health physicians, as outlined in the report, is to provide epidemiological advice to their health authority on setting priorities, planning services, and evaluating outcomes and to develop and evaluate policy on prevention, health promotion, and health education.

Finally, Hannay implies that the Faculty of Public Health Medicine and members have either ignored or been slow to recognise the opportunities that exist in primary care. This year the faculty and the Royal College of General Practitioners jointly sponsored a conference on public health and primary care. Furthermore, there is an active special interest group in the faculty called the Public Health and Primary Care Group, whose objects are to promote public health in the primary care setting by encouraging general practitioners and public health physicians to work together more closely. As Hannay says, these two groups have been too far apart.

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1 Hannay DR. Primary care and public health. *BMJ* 1993;**307**: 516-7. (28 August.)
2 Committee of Inquiry into the Future Development of the Public Health Function. *Public health in England.* London: HMSO, 1988:68-9. (Acheson report.)

Serum screening for Down's syndrome

Not adequately validated

EDITOR,—I share the concerns expressed by various correspondents that the cost-benefit analysis applied so far to biochemical screening for fetal Down's syndrome has been too simplistic.[1] There has been nothing like enough prospective validation of the screening advocated to justify such a major innovation in clinical practice.

Most of the publications advocating screening are simply feasibility studies of the practicalities, with calculations based only on mathematical models. Is it not time for those who believe that statistical associations exist between these various biochemical markers and fetal Down's syndrome to postulate some hypotheses as to how the syndrome results in such altered metabolism? Down's syndrome has a notable range of phenotypic expressions, as would be expected when genetic material of an additional chromosome is involved. How does this fit with such specific biochemical differences? If the associations are