LETTERS TO THE EDITOR

MEDICAL ETHICS AND THE DETECTION OF EARLY CERVICAL NEOPLASIA

From Major P J Fabricius RAMC, Lt Col D W Smith RAMC, Sqn Ldr R M Odbert RAF

Sir, any attempt to increase the detection of treatable cervical malignancy is surely to be welcomed and the recent reminder1 that a smear report of “mild atypia” may conceal more advanced disease should encourage active follow up of this group of patients.

However in their enthusiasm to detect early disease, McCullough and Evans must not lose sight of the ethics and etiquette of medical practice. The result of any cervical smear taken by a general practitioner is confidential information to be shared with the patient.

The pathologist who allows this report to be sent to a gynaecologist is as reprehensible as the gynaecologist who obtains it by any means other than by consultation with the GP.

Adequate follow up of cervical smears will be achieved by skilled interpretation of results and meticulous attention to administrative detail. There is no place for a breach of the ethics of confidentiality or a change in the basis of consultant practice, neither of which has the support of GPs or consultants in Cyprus or we suspect elsewhere within the profession.

We are etc

P J FABRICIUS
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SPIRIT POSSESSION IN NEPAL

From Lt Col J G Dickinson RAMC

Sir, the recent article1 by Melia and Mumford on “Spirit Possession in Nepal” was interesting and instructive. Perhaps I may be permitted to carry the argument for a truly cross-cultural approach to Gurkha medicine a little further, but first to sound some warnings. I remember the first patient who told me he was “bhut lageko”, that is spirit-possessed. He was actually slipping into hepatic encephalopathy. It is also a mistake to assume that indigenous treatment is cheap. A family I know well and who had seen father respond satisfactorily to TB treatment, allowed him to discontinue it after a few months. When he inevitably relapsed, they turned to jhankris and other traditional healers and it cost them over Rs 5000 (about £200 in those days). By the time he came to hospital it was too late. A full course of “developing country” TB treatment costs about Rs 200.

Experience in India has shown that it is possible to integrate traditional healers with modern psychiatric care and that many such healers are quite good at recognising problems that are outside their competence. They have a natural understanding of the beliefs and social systems underlying psychosomatic illness and deal with it in acceptable ways within that structure. The main difficulty lies in securing their co-operation, but once that is done they represent a useful health resource and they need not be regarded as competitors. In an atmosphere of mutual trust, tactful approaches could be used to correct some of their more harmful practices, such as the ligatures described by Strowbridge and Ryan2.

The doctor who seeks to be effective and satisfied in his work with Nepalese will, however, want to gain a deep cultural understanding for himself. He will want to know something of the influences to which Nepalese attribute their illnesses and to know what things indigenous practitioners do and why they do them. He will need to study the many cultural, economic, religious, agricultural and geographical factors that influence the Nepalese understanding of illness. These will help him to appreciate why relatives insist on removing a patient from hospital before death, why touching a dead body may give offence, why the doctors’ and nurses’ traditional white dress represents death to a Hindu, why nocturnal emission of semen is regarded as a disease, why doctors are expected to examine the pulse in both arms, why each patient expects precise instructions on food and drink, why the much more nutritious unpolished rice is unacceptable, why the family economics may quite reasonably give priority to treatment for the buffalo rather than a daughter, and so on. The list could continue almost indefinitely.

I am etc

J G DICKINSON

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CAUSES OF DEATH IN THE ARMY
From Lieutenant Colonel P Lynch MD MRCP RAMC

Sir, Major Finnegan and Mr Lewis1 have done us a great service in underlining so clearly the major causes of death in the Army. I must point out, however, that the Standardised Mortality Rate (SMR) of 92 for coronary deaths which they quote prominently is meaningless and unhelpful. To compare soldiers, of whom 96% are under 40 years old and only 300 or so are over 50, with our ageing civilian population, particularly for a disease which is strongly age related, can only make sense when specific age bands are considered separately. (Otherwise we are effectively saying that the under 50's have less coronary deaths than the over 50's). When this is done, and Miss Gray2 did it very nicely last year, the coronary mortality rate for soldiers between the ages of 20 and 40 years is 1½ to 2 times that of comparable UK civilians.

This is the critical statistic on coronary deaths in soldiers. The other critical statistic, which Finnegan and Lewis point out so clearly, is that road traffic deaths and coronary deaths together account for about half of the 50 or so deaths per year in the Army. Furthermore, if each has an SMR of 150–200 compared with civilians, then about 40–50 deaths per year, a quarter of all deaths, are due to factors present in the Army and not in the civilian way of life. The causes of the “extra” 30–40 road traffic deaths are as yet obscure; the dozen or so “extra” coronary deaths are due to smoking2. So strong is the correlation that other factors like cholesterol and hypertension are, in this context, irrelevant.

So what should be done? Death on the roads is clearly the ACOM schwerpunkt. The need for further investigation is clear. We have to know if the cause is related to fatigue on exercise, as Finnegan and Lewis suggest, dashes to the channel ports, alcohol, foreign traffic laws, or whatever. With the possible exception of alcohol, these questions should be easy to answer.

With regard to coronary deaths, however, the cause is already clear. I contend, though, that any antismoking campaign is off target so long as soldiers in BAOR can buy cigarettes for 30% of their UK price. Cigarette smoking has become an industrial health hazard in the Army and we really are remiss in remaining silent.

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SUNBURN OF THE HEAD IN SOUTH GEORGIA
From Capt G W Bowyer RAMC

Sir, I wish to draw attention to an unusual incident which occurred to a 22 year old soldier serving in South Georgia.

The individual concerned had been on patrol on a very bright day. He had had his hair “cropped” a few days previously, and had not worn a hat during the patrol. Sunscreen had been applied infrequently to his face and neck. He reported sick some three hours after the end of the patrol, complaining that his head was becoming swollen - so much so that his companions had remarked on it – and that it was also becoming painful. Examination confirmed that his head was indeed swollen, particularly around the temples and the forehead, but not around the eyes. Those areas and his scalp were also becoming quite red.

A diagnosis of sunburn was made, and he was treated with Caladryl cream. Over the next few hours the pain and swelling of his head increased; his forehead and temples were tense and tender, and there was pitting oedema. The measured head circumference at this point was 59cm. No protein was detected in his urine.

He was treated with 40mg of frusemide intramuscularly, and slept upright in a chair that night in order to discourage any further swelling.

The next day, the swelling of his head had decreased somewhat, and oedema fluid had gravitated down to his neck. Over the next few days, it disappeared completely, his head circumference was then 55cms. The skin of his face and scalp subsequently flaked and peeled.

This incident underlines the potential hazard of “cropped” haircuts in troops undertaking patrols in the bright sunny conditions of South Georgia, and emphasises the need for head cover and application of sunscreen.

I am etc
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PRACTISING MEDICINE IN NEPAL
From Lt Col G E Ratcliffe RAMC

Sir, two papers in the October 1987 edition of the Journal illustrate very well some of the fascinating features of practising medicine in the Third World, and in Nepal in particular.

The majority of patients seen in BMH Dharan will have sought help from the indigenous practitioners or jhankris to produce the cure to a physical illness. The intervening delay in seeking medical aid sadly allows the disease process to develop to a point beyond aid in some cases.
It must also be remembered, however, that bizarre symptoms in the Nepalese, and in Gurkha soldiers in particular, for which no physical cause can be found, will often respond only to visits to one or more jhankris. The physician in BMH Dharan acts as the psychiatrist when necessary, and my experience certainly corroborates that of Majors Melia and Mumford. I certainly sought the aid of jhankris who in all cases produced the "cure" for the bedevilled. One particular case was cured by the patient practising various "pujas", somewhat akin to prayers, to various people; another involved some repetitive action like sending small packets of rice to a relative on successive days.

It is easy for an outsider to be cynical about such beliefs and it is not within our remit to attempt to bring about radical changes. At the same time, a certain scepticism to Western medicine remains in Nepal, largely the result of ignorance. There remains a great divide between the two schools which will take a long time to close. Nepal is now training its own doctors and the onus must be on these doctors to attempt to combine modern techniques of medicine with these long held beliefs.

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MAJ GEN (RETD) J P Crowdy, L/RAMC


An abridged version of the Presidential Address to the Royal Society of Medicine Section of Epidemiology and Community Medicine, 8 May 1986.

MAJOR S Yogathan, RAMC, MAJOR I G Johnston, RAMC and LT COL I T Houghton, RAMC


Abstract: The authors comment on an article by Mackie in which he attempted to analyse many factors which might determine inspired oxygen concentration in a drawover anaesthetic system. The inspired oxygen concentration depends solely on the patient's minute volume and oxygen supplementation, provided other variables remain constant. We show theoretically that the volume of the reservoir necessary for efficient use of oxygen depends solely on the flow rate of supplemental oxygen and the expiratory time.

Further work by Houghton is reported showing possible causes for the discrepancy between observed and theoretical values of inspired oxygen concentration when using the Triservice anaesthetic apparatus.