a solution that relieved the symptoms somewhat without having to wait for advancement to a higher postgraduate-year level: by designing cloth pockets that would adapt my diagnostic equipment and putting belt loops on these pockets, I was able to create a "utility belt" of diagnostic instruments, which I wore around my waist.

It gave me a somewhat bloated appearance, but my pelvic girdle was clearly better suited for carrying this much weight than was my pectoral girdle. As a dividend, all of my instruments were readily available in emergencies (I was more than once referred to as a "walking crashcart") and I never lost a single instrument to theft, despite the fact that I trained at a notorious inner-city hospital.

Unfortunately, the empty pockets in my white jacket were all too soon filled with manuals and notebooks, so I still suffered from occasional intern's neck; however, I am sure that my symptoms were quite mild compared with those I would have experienced had I carried all of my equipment in the usual fashion.

Education in Ethics for Health Professionals

To the Editor.—I read with great interest the special communication entitled "Health Policy Agenda for the American People: Phase I: The Principles." I was surprised to see that although the document in several places includes either direct or indirect references to ethical principles and the ethical dimensions of the topics addressed by the various work groups, the principles found in group II (education principles) do not direct that ethics should be taught in education programs for the health professional.

The agenda acknowledges the need to address ethical considerations in the areas of research, systems of health care provision, and evaluation, assessment, and control. However, if health care professionals do not understand ethics because their educational preparation does not require the study of ethics, health care personnel will be ill-prepared to address these ethical issues and the health care personnel group should include as one of its education principles an education in ethics.

I commend the work of the policy agenda members. It is a very stimulating and useful set of principles to guide the decision making for American health care in the next decade.

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In Reply.—While there is no principle from Phase I of the Health Policy Agenda that specifically directs that ethics be taught in programs of health professions education, the role of ethics in health professions curricula is being addressed by several policy proposals in Phase II of the Health Policy Agenda. These are the proposals of work group 5 (evaluation, assessment, and control principles) on ethical consideration in health care, and work group 1 (medical science principles) on biomedical research and its biological, medical, ethical, and legal implications. It would have been impossible to cover all of the specific content concerns of medical education curricula in separate principles during Phase I. There are, however, several principles that address the need for curricula to be broadly responsive to societal needs.

The Weil-Felix Test Is Archaic and Misleading

To the Editor.—Zaerlein and Smith1 have appropriately recommended that the Widal group of febrile agglutinin tests should be abandoned because of their dismal predictive value. They unfortunately did not heed their own data or the past recommendations of others2 also to abandon the equally archaic and misleading Weil-Felix reactions. Numerous studies have clearly demonstrated the lack of sensitivity and specificity exhibited by these tests in the diagnosis of rickettsial disease.

While mentioning complement fixation as an alternative test along with direct fluorescent antibody testing of biopsy specimens, the authors appear to be unaware of a much more sensitive and specific test now available, the microimmunofluorescent test.3 This test is available, usually with a 24- to 48-hour turnaround time, from most of the larger commercial reference laboratories. It is an indirect fluorescent antibody test that utilizes either a single dilution (screening test) or multiple dilution (quantitative titer) of patients' sera. This is reacted against yolk sac cultured antigens of spotted fever group or typhus group rickettsiae. Reaction is then indicated by a fluorescent-labeled anti-human globulin. Specific reactions with anti-human IgM are indicative of recent infection. Other tests that are available on a limited, primarily investigational basis include latex agglutination and enzyme-linked immunosorbent assay tests. These may become commercially available in the future.

Given the availability of more specific and sensitive methods, the continued utilization of the Weil-Felix reactions cannot be considered to be appropriate medical practice. Their continued use should be equated with the use of the thymol turbidity and cephalin flocculation tests for the diagnosis of hepatic disease, anachronisms that are inappropriate in modern medical practice.

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In Reply.—I agree with Dr Newby that the Weil-Felix test is much less desirable for diagnosing Rocky Mountain spotted fever than the complement fixation test or the microimmunofluorescent test. However, the Weil-Felix test continues to be used because of convenience and accessibility. The microimmunofluorescent test is not widely available at the present time, while the complement fixation and Weil-Felix tests are readily available.1 More specific tests for Rocky Mountain spotted fever will, I hope, eventually replace the nonspecific serological tests.

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