General practitioner obstetrics: does risk prediction work?

Sir,

The study by Reynolds and colleagues (July *Journal,* p.307) shows that a considerable proportion of pregnant women, who, according to conventional criteria, were at low risk of developing complications, did in the event develop them and were duly transferred for consultant care. This finding leads the authors to ask whether other criteria could be identified which would more accurately predict the non-occurrence of complications and so obviate the need for transfer.

To begin to answer this question, it would be necessary to know the incidence of the same complications among the women who failed to fulfil the same selective criteria. The Oxford obstetric data system could probably be dredged to yield this information.

But more fundamental is the need to measure outcome — mortality and morbidity of mother and child — in order to establish whether the women transferred were the better for the transfer, that is, whether the interventions to which they were subjected decreased the risk to babies associated with the complications. Other data give reason to suspect that they do not.

For example, official statistics[1,2] show specific stillbirth and perinatal mortality rates in all maternal age groups, older as well as younger, and at all parities to be lower in isolated general practitioner units than in consultant hospitals. The *British births 1970* survey showed that, using the obstetricians' own measure of comprehensive risk, specific perinatal mortality rates at all levels were highest in consultant hospitals.[3] In New Zealand in 1978–81 perinatal mortality rates for the 99% of births weighing 1500 g and over were significantly lowest in the least specialized hospitals.

Clearly, if the maternity service is to be organized to provide the greatest safety and satisfaction for its clients, the overriding need is for evidence to support or refute the hypothesis, hitherto untested, that obstetric management is especially valuable to babies who are at risk because their mothers have certain characteristics or obstetric experiences. Unless there is evidence to support this hypothesis, there is no point in identifying criteria which will more accurately predict the occurrence of complications. Surely the Oxford data system could be used to search out this information, if those who have access to it dare to do so?

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Malaria prevention for travellers to west Africa

Sir,

Dr Phillips-Howard and colleagues' advice on malaria prevention for travellers visiting west Africa (May *Journal,* p.226) is open to dispute principally because of their recommendation to use chloroquine weekly for prophylaxis albeit in combination with daily proguanil. In Zimbabwe we have, rightly or wrongly, blamed the increasing resistance of *Plasmodium falciparum* to chloroquine in established cases of malaria on our recommending its use for prophylaxis over the years: this is now discouraged here because of the false sense of security it may give and because it may further promote chloroquine resistance.

The College of Primary Care Physicians of Zimbabwe in conjunction with the Blair Research Laboratory in Harare recommend pyrimethamine plus dapsone for prophylaxis (Deltaprim, Wellcome) or amodiaquine for hypersensitive patients. For adult treatment they recommend four tablets of chloroquine base (150 mg) at once, then two tablets in six hours and two daily for two more days. Even in chloroquine susceptible malaria the parasites may remain in the blood for three days and the temperature high for at least a day after treatment. If it still remains elevated after this, one of the following courses is given: (1) a single dose of three tablets (pro rata for children) of pyrimethamine/sulfadoxine (Fansidar, Roche); (2) quinine 600 mg three times a day with tetracycline 500 mg three times daily for seven days (not for children under eight years old); or (3) two tablets of co-trimoxazole (pro rata for children) twice a day for five days.

I would like to make a special plea to doctors in the UK: please do not prescribe Fansidar for prophylaxis, not because of the risk of serious skin reactions or other side effects, but because to do so might increase the strains of *P. falciparum* already suspected of being resistant to this drug combination.

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There is no perfect answer to malaria prophylaxis and treatment and recommendations from British authorities and from the World Health Organization do differ from the recommendations of doctors working in countries such as Zimbabwe. For example, doctors here generally consider proguanil to be a useful drug, whereas amodiaquine is not recommended because of the risk of agranulocytosis. Perhaps mosquito nets will regain their popularity as they may be more cost effective than drug prophylaxis in east Africa. (Ed)

HIV infection: ethical problems for general practitioners

Sir,

I would like to expand on several points in Morris Gallagher's excellent article concerning ethical problems for general practitioners dealing with patients with human immunodeficiency virus (HIV) infection (September *Journal,* p.414).

Although he is concerned about the issue of confidentiality he perhaps does not go far enough. In family medicine, a case could be made for absolute confidentiality as practised by clinics for sexually transmitted diseases where medical information is never divulged, regardless of the reasons, should the patient not agree. Clinic doctors are faced daily with HIV patients who admit to unprotected sexual intercourse and, as difficult as this knowledge may be for doctors to hear, absolute confidentiality guarantees trust by the patient. The majority of people are open to persuasion and although patients who ultimately refuse to follow guidelines to protect their partners cause great difficulty for the doctor, perhaps the greater good is to remain silent. When patients suspect that their doctor may eventually leak such vital information they will simply cease to confide in him or her.

Dr Gallagher's objection to the commercial intrusion of insurance companies could also be carried further. If general practitioners as a profession decided not to provide medical reports on their patients for insurance companies, the companies would be forced to rely on more appropriate sources such as the patient's own report, with recourse to independent medical opinion where it was deemed necessary. Only then would patients' trust

in their general practitioner re-establish itself. One of the principal reasons patients do not confide in their doctors about their sexual orientation or HIV status is fear of lack of confidentiality[1] including that related to insurance companies. Sadly, it is becoming increasingly common for homosexual men to bypass their NHS general practitioner in favour of a private doctor with whom they can be frank. By so doing they maintain a clean slate with their 'official' family doctor for purposes of medical reports while receiving their actual medical care elsewhere.

I would disagree with Dr Gallagher's presumption that a dislike of homosexuality is common in the medical profession. In our recent survey of over 1200 general practitioners practising in London (report in progress) almost three-quarters considered that homosexuals should be accorded equal rights and freedoms with heterosexuals.

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Just close your eyes and relax

Sir,

Thank you for publishing the review of *Just close your eyes and relax* (July *Journal,* p.331). I note the reviewer's criticisms of the tape and I would be the first to admit that the technical quality is far from perfect. However, it must be remembered that the tape is designed to be listened to over and over again, and susceptible subjects will be in hypnosis by virtue of the post-hypnotic suggestions and will not need to follow the induction procedure after the first few occasions. Indeed, using Gindes equation[1] — misdirected attention plus belief plus expectation equals the hypnotic state — the fact that there may not be enough time to complete the counting or the muscle relaxation is irrelevant to the process of hypnotic induction. Hypnosis is not the same as deep relaxation and is therefore not encumbered by the laborious need to reproduce lengthy procedures regularly. While I acknowledge the reviewer's reservations, I would like to point out that an almost identical programme has already given encouraging results.[2] It seems that the problems highlighted are much more of a problem to the reviewer than they are to the participant and perhaps this is because hypnosis is fundamentally a right hemisphere state, whereas appraisal is purely a left hemisphere phenomenon. I hope that potential users will not be unnecessarily put off as it does seem that the programme has already shown its value.

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Nurse practitioners

Sir,

I read with interest the paper on nurse practitioners (July *Journal,* p.314). Unfortunately, I feel that it ignores some very important issues. As a general practitioner I was trained to deduce from symptoms, elicit signs and make a diagnosis, a most difficult task in a busy surgery. Nurses are untrained in these skills. They are trained to understand the patient's physical and mental needs in the face of a given diagnosis. We must make better use in general practice of skills that nurses are trained for, not push them into inappropriate areas. It is a recipe for disaster.

Perhaps the time has come to face the issue head on and train 'bare-foot doctors'. If there is a demand for someone other than a doctor to diagnose patients, and personally I am not convinced of this, let it be someone appropriately trained.

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Recording preventive information

Sir,

Your report of methods of recording blood pressure and smoking habits (News, August *Journal,* p.386), reminded me of a project which I had hoped to introduce in our practice before my retirement made indolence respectable. This was for a small rubber-stamped box in the left-hand margin on each continuation sheet in the record envelope, designed to remind the general practitioner of important preventive information at every consultation. Small stamps are easily and cheaply available to one's own design.

It is important that the record stands out at every consultation, that completion and updating is as simple and quick as possible, and that the information is of value to all those who use the notes. I wish my records had included such an item.

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Partnerships in general practice

Sir,

In *Continuing education for general practitioners*[1] Branthwaite and colleagues paint a gloomy picture. This interesting paper highlights many problems, not least, those caused by partnership difficulties. It is encouraging to read that most general practitioners were committed to promoting good primary care but disheartening to read that the difficulties experienced in implementing change within the practice caused frustration and discontent among young practitioners.

I have recently come to believe that in future more continuing education will take place within the practice itself. This can partly overcome the problem of the time involved, and since it is directly related to patient care, it improves motivation. Case discussions and topic presentations with one partner responsible for providing background information are fruitful ways of practical learning. However, if partnership difficulties are an impediment to such an obviously rich way to learn, then we should be urgently analysing what is wrong with the processes and dynamics of partnerships in general practice.

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Reference

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Wanted — practice annual reports

Sir,

I am a member of the College at present doing some research on the annual report. If your practice produces an annual report I would be very interested to see a copy. Please send it to me at the address below; I will be pleased to refund any costs incurred.

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