with financial problems. Ten identified a need for help in enabling refugees to adjust better to living in this country, for example, on ways of overcoming their feelings of isolation.

In general, although some general practitioners had developed links with voluntary services, overall there appeared to a lack of targeted statutory services. This may in part be a result of limited access to information about services. Further evaluation of the provision of services would help to resolve this point.

With increasing numbers of refugees, a coordinated approach to providing a service for members of refugee populations will be essential.[1] The best method of service delivery remains open to discussion. Greater dissemination of skills, rather than simple reliance on expert centres, may be important in providing comprehensive care for these patients.[2]

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Health care for homeless people

Sir,

The homeless population is not a single homogeneous social group, rather it may have subdivisions of people with varying health problems and needs. One such subdivision is the temporary homeless population living in bed and breakfast accommodation prior to permanent rehousing. This group appear to be high users of services provided by the secondary care sector. The bed and breakfast homeless population accounted for 8% of all emergency admissions to an inner London teaching hospital[1] and an estimated 7500 unplanned acute hospital admissions annually in London.[2] These high levels of utilization have raised concerns about access to primary care available for the temporary homeless population. Using data from the North West Thames Regional Health Authority health and lifestyle survey[3] an analysis was undertaken of the use of general practitioner services by those living in bed and breakfast accommodation and compared with that of residents in the area as a whole (not all respondents answered every question).

Of the sample, 54.1% had been in their hotel for less than three months and 23.3% had been there for over six months. Overall, 92.9% of the 319 subjects were registered with a general practitioner; 44.6% had been registered for less than one year and 18.2% lived more than five miles away from the surgery.

One quarter of the 319 subjects (26.7%) had consulted their general practitioner within the 14 days before interview; this consultation rate was approximately double that reported by the resident population (that is, excluding the homeless) (13.0% of 528 subjects). Virtually all the homeless people in bed and breakfast accommodation (85.2%) had consulted their general practitioner within the last year. Six per cent had seen a nurse in the previous 14 days and 4.2% had seen a health visitor (for the regional population the rates were 3.1% and 1.2%, respectively). Of the 319 homeless subjects 42 (13.2%) had visited a casualty department in the previous three months. Of these, only one was not registered with a general practitioner and 38 had consulted a general practitioner during the same period that they had attended a casualty department.

In London, there are concentrations of homeless people living in hostels and temporary bed and breakfast hotels. It is widely assumed that homeless people use secondary care services (especially casualty departments) because they are not registered with a general practitioner. For the homeless population in bed and breakfast accommodation in this survey, rates of general practitioner registration were high (93%). Several factors may account for this. First, the official homeless population are more settled than the more transient, roofless population. Secondly, within north west Thames region there are several innovative schemes which aim specifically to provide primary care to homeless people in hotels, for example, the Bayswater families doctors practice. This practice probably accounts for the observation that almost half of the sample had been registered with their general practitioner for less than one year.

Access to primary care is not simply a matter of registration with the general practitioner. Another factor is proximity of the practice. Homeless people from all over London may be placed in bed and breakfast hotels within north west Thames region. This may account for the finding that a high percentage of homeless people were registered with a general practitioner who was not local. This may also reflect the reluctance of many homeless people to change their general practitioner when they are placed in temporary accommodation: changing general practitioner may be a tacit admission that their stay is not going to be temporary. One study found that the mean length of stay in bed and breakfast accommodation was 13 months.[4]

Over a quarter of the sample of homeless people had consulted the general practitioner within the last 14 days. Of those who had visited a casualty department, almost all had consulted with their general practitioner over the same period. This would suggest that casualty departments are not simply being used by homeless people as a substitute for primary care.

Rates of long-term health problems and mental health problems among those in bed and breakfast accommodation are at least twice those for regional residents.[3] Given the high rate of mental and physical morbidity it may be that homeless people are under-users of services rather than over-users.

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Citizens' advice bureaux

Sir,

With recent changes to community care, and general practitioners' relatively poor knowledge of social security benefits, it has been suggested that providing citizens' advice in general practice would satisfy many unmet needs.[1] A recent study in Birmingham concluded that citizens' advice bureau sessions in general practice were an effective way of providing advice on life problems and securing proper payment of benefits, particularly to patients with health problems.[2]

Sandwell Family Health Services Authority and our local citizens' advice bureau have operated a pilot scheme of

citizens' advice in general practice since October 1992. Four practices, including our own, were selected, and a citizens' advice bureau worker has attended our surgery twice a week, available for consultation for approximately 11 hours each week. In our practice although initial interest was low, use of the service increased from six consultations (eight enquiries) in November 1992 to 46 consultations (111 enquiries) in April 1993. Anyone living within our practice boundary, even if not registered with us, may attend. Employment, family and personal issues, tax and debt enquiries tend to predominate. Audit shows that 20% of enquiries are repeat enquiries, indicating users are keen to bring further details to the citizens' advice bureau adviser, which is a strong demonstration of consumer satisfaction. We hope that the service will continue to be funded, because of its valuable contribution to the work of our primary health care team.

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Traveller Gypsies and childhood immunization

Sir,

The paper about immunization levels in Traveller Gypsy children recommended outreach services to caravan sites (July *Journal*, p.281). In the Newry and Mourne Unit of Management, Northern Ireland an onsite clinic was established in a local traveller community in 1989. This provides a weekly clinic run by health visitors and a monthly clinic run by a senior clinical medical officer. It is estimated that 20% of the children attending this clinic have medical/developmental problems which may affect their future potential.

Since the clinic was set up immunization uptake rates have improved considerably. In May 1992, the primary immunization uptake rates of traveller children were compared with children in the settled community. It was found that 100% of the 35 traveller children and 96% of the 28 560 children in the settled community had received their diphtheria/tetanus/polio immunization, 64% and 90%, respectively, had had their whooping cough immunization, and 100% and 95%, respectively, had had their measles/ mumps/rubella immunization.

These figures show that it is possible to increase the uptake of immunization in the traveller community by modifying services to take account of their special circumstances.

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Endometrial sampling

Sir,

Increasing numbers of women receive hormone replacement therapy from their general practitioner (Scottish Medicines Resource Centre, 1991). Irregular bleeding can occur with hormone replacement therapy and current advice on management of this is vague: 'If bleeding is obviously associated with poor compliance, antibiotic therapy or gastrointestinal upset no investigation is required. If more serious causes are suspected then an endometrial biopsy... is required.'[2] It is uncertain upon what basis such suspicions can be objectively founded. Endometrial sampling by the general practitioner would quickly resolve any uncertainty about endometrial cancer. A study was carried out in general practice to determine if endometrial sampling by the general practitioner was acceptable to the woman, the general practitioner, the gynaecologist and the pathologist.

The study involved three general practitioners based in three different surgeries. In two surgeries, the technique was already being used. One author (D G) was based in the third. Asymptomatic women receiving hormone replacement therapy were chosen as the study group; 33 women were invited for endometrial sampling. The samples were intended to be taken in the week prior to menstruation although this was not possible in every case. Two contiguous 10 minute appointments were booked for each patient and the practice nurse assisted in the second part of the double appointment. The details of the procedure have been reported elsewhere.[1] After sampling, each woman was given a questionnaire to complete.

Samples of the endometrium were obtained from 28 women. The procedure did not have to be abandoned because of reported pain in any woman, although in four women it proved impossible to negotiate the cervix. For one woman, no material was obtained in the sample, indicating that the uterus had no significant pathology. Histological findings were: secretory endometrium 22 women, proliferative endometrium three women, atrophic endometrium two women and endometrial hyperplasia one woman.

The 28 women from whom a sample was obtained stated that they would undergo the procedure again if it was thought necessary.

The procedure is already routinely used in the outpatient department at the local district hospital to investigate abnormal vaginal bleeding. The reservations which may be expressed concerning use of the device by general practitioners would centre around the competence of those performing the procedure. The general practitioners in this study were taught the technique by a gynaecologist. It was easy to learn and was less technically demanding than the insertion of an intrauterine contraceptive device.

The management of women with abnormal vaginal bleeding has traditionally been undertaken by the hospital consultant and has relied on examination under anaesthesia and dilatation and curettage. The introduction of endometrial sampling procedures provides an opportunity for the general practitioner to invesigate these women.

Access to endometrial sampling can only contribute to the early diagnosis of endometrial abnormalities. The study identified one case of endometrial hyperplasia in a healthy, asymptomatic woman taking conjugated oestrogens, with progestogen. It has been claimed that combined hormone replacement therapy reverses endometrial hyperplasia.[3]

It would appear from the results of this study that appropriately trained general practitioners could offer endometrial sampling to women with postmenopausal bleeding or who are taking hormone replacement therapy and have irregular bleeding. To our knowledge this is the first study demonstrating the applicability of the technique in the general practice situation.

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