# LETTERS


Screening out non-infected urine samples
*Malcolm K Lindsay and Ruth Johnston* 36

Future of general practice
*J Hedges* 36

Care of long-term mentally ill people
*Tony Kendrick,* et al. 37

Double-blind, randomized controlled trial
*Peter M B English and Angie C Titchen* 37

Spirituality, healing and medicine
*Paul R Kettle; M G Sheldon; Ivan Benett; Craig K Brown* 38

Chronic fatigue syndrome
*Sean Lynch,* et al. 39

Patient satisfaction and style of practice
*Domhnall Macauley* 40

Reflotron measurement of blood cholesterol
*F A Majeed* 40

Reaccreditation of GPs
*Philip Schuppler* 40

Audit in general practice
*A G Baird* 41

Surgical simulation for general practitioners
*N K Menon* 41

Appliance for hemiplegic patients
*J Brims,* et al. 41


**Note to authors of letters:** Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

## Screening out non-infected urine samples

Sir,

Hiscoke and colleagues recommended that clear urine samples with negative strip tests for blood, protein and nitrite do not require laboratory culture as the predictive value of these tests for the absence of bacteriuria was 98.5%.[1]

We tested 282 consecutive urine samples over a five month period, assessing appearance and testing with N-labstix® (Ames) for protein, blood and nitrite, before sending for laboratory culture. Of the 282 samples 82 (29.1%) were assessed as clear in appearance and gave negative strip results, and 78 of these negative specimens were shown not to have significant bacteriuria, giving a predictive value for the absence of bacteriuria in these samples of 95.1%. Significant bacteriuria was found in 65 (23.0%) of the 282 samples. We have therefore confirmed the value of the method of screening out non-infected urine samples but would like to comment further on one aspect of the method which may cause difficulties to those using it.

Assessment of urine appearance as 'clear' or 'turbid' is subjective and we soon became aware that some samples fell into a doubtful category. We analysed this by comparing practice and laboratory assessment of urine clarity. Testers were asked to assess as 'clear' only those specimens in which there was no sign of turbidity, sediment or debris. Laboratory assessment was made about three hours after the practice assessment. A total of 267 specimens were compared.

In 57 of the 267 specimens (21.3%) there was disagreement between the practice and laboratory. Either the appearance of these samples changed in the time between tests or there was difficulty in judging the clarity of the sample. However, only one of these samples showed significant bacteriuria. We therefore conclude that testing for clarity is practical and valid and while recommending that testers should be strict in the assessment of clarity, there appears to be a safety net in that dubious samples are as unlikely to be bacteriuric as those that are undoubtedly clear.

With regard to the relevance of the method to clinical practice, we acknowledge that its application would lead to a reduction in laboratory workload and costs. The rapid identification of non-infected samples will help management decisions in symptomatic patients but use of the method is unlikely to have an appreciable effect on antibiotic prescribing as many of the clear, strip negative samples will be from patients without immediate therapeutic needs.

Practitioners using the method must be aware that there is a small risk of wrongly excluding bacteriuric samples and it may be judged that this risk is not justifiable where the diagnosis of urinary tract sepsis is extremely important, for example in children.


MALCOLM K LINDSAY
RUTH JOHNSTON

Galashiels Health Centre
Currie Road
Galashiels TD1 1AU


**Reference**


1. Hiscoke C, Yoxall H, Greig D, Lightfoot NF. Validation of a method for the rapid diagnosis of urinary tract infection suitable for use in general practice. *Br J Gen Pract* 1990; **40**: 403-405.


## Future of general practice

Sir,

*'Omnia mutari constat* [It remains certain for all things to be changed]'[1] might be thought to be a classical translation of contemporary feelings engendered by the increasing speed of change in the National Health Service and particularly in family care. Thus, it is salutary to realize that the quotation is from Francis Bacon who, even in the 17th century, noted that change was a basic facet of life.

The General Medical Services Committee document *Building your own future*[2] which promotes active management of future change in the style and content of general practice in the United Kingdom, is a welcome development. Members of the Royal College of General Practitioners in the Cambridge and Huntingdon districts held a meeting to discuss how *Building your own future* could be developed in line with the type of general practice they would like to see themselves working in by the year 2000.

Despite members representing a broad cross-section of local general practitioners, a surprising degree of consensus emerged, based on the caveat 'Do not undervalue the exceptional standard of service and cost efficiency that modern general practice offers the nation'. There is no doubt that protected time for specific aspects of general practice is profitable. Studies on the effects of a reduction in average list size, slowing of consultation rate and non-critical examination of performance all show enhanced patient care.[3-5] The provision of adequate time for all aspects of general practice will be crucial in nurturing the type of practice the group hopes to work towards.

Aware of the contribution of general practice to the health of the nation, the group felt confident that all political parties would wish to encourage future development of this national asset. Members foresaw general practice, at the end of the millenium, to be based on a contractual system. Family health services authorities will buy primary care for defined populations from general practice consortia who will provide fully integrated services to their practice populations, either by employing health care professionals directly or sub-contracting areas of care to self-regulating, independent, health care professionals. The salaried option will have become irrelevent, for once accredited as having completed vocational training for general practice, a doctor will be entitled to be called a principal and would either work as a salaried employee of a general practice consortium or be more involved in the management and contractual responsibilities of the consortium, as a sharing partner in the business.