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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.

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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.

The problem of an individual contract that specifies a 24 hour, 365 day per year availability to patients would be negated by the devolvement of such responsibility to the general practice consortium as a whole. However, a useful degree of continuity of patient care would be retained, owing to the commitment of members of the consortium to their patient 'list'. Patient choice will be ensured by the control which family health services authorities will have over placing contracts, thus fostering the variety and diversity of general practice, so necessary to a nationally directed system that retains responsiveness to local needs.

Current discussion about reaccreditation will have been resolved by a system of continual reaccreditation by audit, adequate time and resources having been given for family health services authorities to monitor the performance of consortia based on health outcome, and for general practice consortia to monitor, advise and direct postgraduate education for their principals by unobtrusive, computer-based, information-gathering technology.

Educational development is the forte of modern general practice in the UK and by the year 2000 the education of medical students will be primarily general practice based, opening up opportunities for the study of disease and its impact, physical, psychological and social, on individuals and the community at large. Postgraduate education will have been improved by making general practice experience a mandatory requirement for the general professional training phase for all hospital-based specialties. For accredited general practitioners, postgraduate education will have become more flexible, based on the active participation of all principals in local standard setting and the development of local disease management protocols, involving close interaction with hospital-based specialists.

These changes, having been evolved in consultation with the profession by successive governments, will ensure a less stressed practitioner and less stressful working environment. These are the rewards of a worthwhile job well done, with adequate resources to do that job, increasing the motivation and efficiency of general practitioners.

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Care of long-term mentally ill people

Sir,

Dr Elizabeth Horder's editorial (October *Journal,* p.399) has highlighted an area which concerns all general practitioners: the problem of providing good primary medical care for people with long-term mental illness in the community.

It is difficult to estimate the total number of long-term mentally ill people outside hospital who are socially disabled by the sorts of illnesses which Dr Horder describes. A conservative estimate is about 180 000 (0.5% of the 36 million adult population of England),[1,2] of whom only a proportion are former long-stay patients.

Dr Horder addresses the primary medical care needs of those housed in hostels. This group have at least been identified and provided with special care. The main challenge general practitioners face is how to provide primary medical care to the majority, that is, those living independently, with families, or in lodging houses.

Many people with long-term mental illnesses, such as schizophrenia, are withdrawn and inactive and do not make demands on their doctors, so that their mental and physical problems may be neglected until they build up to a crisis. General practitioners may be unaware of the problems of their long-term mentally ill patients, or even of their existence. Even when the patient sees the doctor there may be considerable barriers to communication including hallucinations, delusions, and lack of insight. Most general practitioners and their staff lack training in dealing with these patients, and this must contribute to negative attitudes towards taking on their care. Research carried out from St George's Hospital Medical School has shown that such patients pose many problems in practice and that they are often seen by general practitioners only when crises develop. Very few general practitioners have specific policies for the care of the long-term mentally ill.[2]

There is, therefore, a need to improve the provision of primary medical care to all long-term mentally ill people. With the help of the Mental Health Foundation we are testing the feasibility and impact of setting up practice-based call–recall registers of these patients, and training general practitioners in the use of a structured assessment of such patients at regular intervals.

Long-term mentally ill people should be encouraged to live outside residential care and be treated as normally as possible. They are an at-risk group which needs a special proactive approach, but they are no different in principle to other groups such as under five year olds and over 75 year olds. By organizing ourselves to seek out long-term mentally ill patients at regular intervals, we general practitioners might avoid seeing such patients only at times of crisis, or even worse, neglecting them altogether.

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Double-blind, randomized controlled trial

Sir,

We were interested to read Dr Charlton's editorial (September *Journal,* p.355).

There are different kinds of knowledge; different philosophical bases for knowing. One of these is 'technical-rational' knowledge, derived through positivist science, such as the double-blind control study. Another kind of knowledge, as Charlton recognizes, is 'craft knowledge' which professionals acquire through experience.

Craft knowledge may be tacit and unarticulated,[1] as suggested by Charlton in his description of the brilliant doctor who cannot explain why she/he achieves better results than others. Schon argues that the practitioners can generate theory or craft knowledge from their own practice when they meet an unusual situation.[2] This leads to 're-framing' the problem, or 'on the spot' experimentation, and is part of craft knowledge.

The philosophical base for generating knowledge must match the sort of