Department of General Practice
University of Limburg
PO Box 616, 6200 MD Maastricht
The Netherlands

Reference

1. Murphy E, Spiegal N, Kinmonth A-L. 'Will you help me with my research?' Gaining access to primary care settings and subjects. *Br J Gen Pract* 1992; **42:** 162-165.

Working with social services departments

Sir,
We are concerned that poorly developed inter-agency cooperation may be hampering the implementation of the children act 1989. The document *Working together under the children act 1989* states that the protection of children requires a close working relationship between social services departments, the police service, medical practitioners, community health workers, schools, voluntary agencies and others.[1] As general practitioners and health visitors in a primary health care team we do not have a balanced working relationship with our local social services child and family team. We have a considerable workload with children on the protection register, and the geographical proximity of the health centre to the social services office allows the general practitioners to attend case conferences more frequently than doctors in many other localities.

The following is a description of some of the problems we have encountered. Our concerns about individual family situations seldom influence the decisions that are made, and we have detected little willingness on the part of the social services department to integrate other professionals' opinions into their decision making. Our referrals of families for preventive work are rarely acted on convincingly, lack of resources being cited as the predominant reason. We are concerned by the many dysfunctional case conferences we have attended: there is too great a focus on whether to place a child on the protection register, so inhibiting the drawing up of a wider child protection plan. Decisions at case conferences are made on insufficient information, while at other times indiscriminate or inappropriate information is provided. An insistence on voting for decision making is often divisive and inappropriate, as 'one person one vote' leads to the view of the social services department predominating. Case conferences become confrontational if opinions other than the prevailing view of social services are expressed, with chairpersons failing to facilitate the working together of different professions. There is scanty implementation of policies or procedures for working with parents in case conferences. We are also concerned that core groups (for example, a social worker, a health visitor and a general practitioner) can fail to work, with patchy and incomplete follow up of children.

While we have made representations at a local level to try to improve working relations with social services we do not feel this has been successful. Our approaches at a county level initially led to us being able to express our concerns but this, several months on, has not yet led to anything concrete. We therefore wish to ascertain whether other primary health care teams are experiencing similar problems in their working relationships with social services. If this is so we would welcome suggestions on how to progress towards a generalizable solution.

PENNY OWEN
PAUL KINNERSLEY
ELEANOR BROWN
MARGARET JONES
KATE MONTAGUE

Department of General Practice
University of Wales College of Medicine
Llanedeyrn Health Centre
Cardiff CF3 7PN

Reference

1. Home Office, Department of Health, Department of Education and Science and Welsh Office. *Working together under the children act 1989.* London: HMSO, 1991.

Aspirin and myocardial infarction

Sir,
The discussion paper by Dr Rawles presents a well argued discussion on the acute management of patients with myocardial infarction, with particular emphasis on recent advances relevant to general practice.[1]

Our only concern about this paper is the absence of reference to aspirin. The ISIS-2 trial demonstrated a 25% reduction in mortality when 160 mg aspirin was given within the first four hours of the onset of chest pain.[2] Birkhead demonstrated that for patients admitted with chest pain by their general practitioner the median time by which they received thrombolytic treatment was over four hours.[3] The ISIS-2 results demonstrate that the effect of aspirin is somewhat less when it is given more than four hours after the onset of chest pain.

It would therefore seem reasonable for all patients with suspected myocardial infarction to be given 150 mg of aspirin immediately when first seen by the general practitioner. This treatment is more likely to be acceptable to general practitioners than the administration of thrombolytics at this time. Further, the finding that patients are admitted substantially quicker if they call the ambulance themselves, suggests that the time may be right to consider whether aspirin should in fact be carried and given by ambulance crews.

NEIL JOHNSON

The Medical Centre
Badgers Crescent, Shipston on Stour
Warwickshire CV36 4BQ

MICHAEL MOHER

Southmead Surgery
Blackpond Lane, Farnham Common
Buckinghamshire

References

1. Rawles J. General practitioners and emergency treatment for patients with suspected myocardial infarction: last chance for excellence? *Br J Gen Pract* 1992; **42:** 525-528.
2. Second International Study of Infarct Survival Collaborative Group. Randomized trial of intravenous streptokinase, oral aspirin, both, or neither among 17 187 cases of suspected acute myocardial infarction: ISIS-2. *Lancet* 1988; **2:** 349-360.
3. Birkhead JS. Time delays in provision of thrombolytic treatment at six district hospitals. *BMJ* 1992; **305:** 445-448.

James Mackenzie

Sir,
James McCormick (letters, June *Journal*, p.262) challenges the assertion in my Mackenzie lecture (February *Journal*, p.78) that coronary thrombosis, or myocardial infarction, was rare at the beginning of the century and was not described by James Mackenzie. This challenge is a repetition of that[1] issued to a previous Mackenzie lecturer, Walter Yellowlees, 14 years ago.[2]

Yellowlees' detailed response[3] provided much of the evidence supporting our contention (and that of Mackenzie's biographer, Professor Alex Mair[4] that myocardial infarction was only just becoming recognized at the time. It may be true that, as McCormick suggests, 'angina' included some cases of 'infarction'. However, the fact that Mackenzie, writing about angina, stated that 'there are cases in which angina pectoris develops with great severity and ends speedily in death. On the whole these cases are rare'[5] and 'great as the distress is which the pain produces, pain itself is in no sense a dangerous symptom'[6] suggests that, even if 'angina' included 'infarction', the latter was not common. Review of pathology reports for autopsies carried out at the London Hospital during the period 1908–13 (when Mackenzie was cardiologist there) indicated that, al-

though atherosclerosis and calcification were seen, intraluminal thrombosis was rare.[7]

GODFREY FOWLER

Department of Public Health and Primary Care
University of Oxford
Gibson Building, Radcliffe Infirmary
Oxford OX2 6HE

References

1. McCormick JS. James Mackenzie lecture [letter]. *J R Coll Gen Pract* 1979; **29**: 248.
2. Yellowlees WW. Ill-fares the land. James Mackenzie lecture 1978. *J R Coll Gen Pract* 1979; **29**: 7-21.
3. Yellowlees WW. Sir James Mackenzie and the history of myocardial infarction. *J R Coll Gen Pract* 1982; **32**: 109-112.
4. Mair A. *Sir James Mackenzie, MD 1853-1925, general practitioner.* Edinburgh: Churchill Livingstone, 1973.
5. Mackenzie J. *Principles of diagnosis and treatment in heart affections.* London: Henry Frowde and Hodder and Stoughton, 1916.
6. Mackenzie J. The surgical treatment of angina pectoris. *Therapeutic Gazette.* 1924; 15 November.
7. Morris JN. Recent history of coronary heart disease. *Lancet* 1951; **1**: 1-7.

Research in general practice

Sir,
Dr Craddock's letter (February *Journal*, p.86) raises the issue of research by general practitioners. I agree with the view that research in general practice is both possible and worthwhile. Unfortunately, there may be a decline in the proportion of practices who are undertaking research.

I undertook a survey in 1982[1] and 124 of the practices in that study responded in the 1990 survey referred to by Dr Craddock.[2] In 1982, 39 of the 124 practices reported undertaking individual research of some kind, but in 1990 this number had fallen to 27. In 1982, 27 of the practices were taking part in some type of collaborative research, but in 1990 this figure had fallen to 19.

While this information is from a relatively small number of practices, if it does reflect a general trend, there is a depressing reduction in the proportion of general practices taking part in research. Possible explanations include the increase in pressure of work and changing attitudes among general practitioners towards research. This finding is worrying for those who wish to see general practice continue to develop a sound academic foundation. It is clearly important that further work be undertaken to confirm whether or not there is a genuine decline in research being undertaken by practices. If a decline is found, it is essential that the explanations for this are identified so that appropriate action can be taken.

RICHARD BAKER

Eli Lilly National Clinical Audit Centre
University of Leicester School of Medicine
Leicester General hospital, Gwendolen Road
Leicester LE5 4PW

References

1. Baker R. Comparison of standards in training and non-training practices. *J R Coll Gen Pract* 1985; **35**: 330-332.
2. Baker R. General practice in Gloucestershire, Avon and Somerset: explaining variations in standards. *Br J Gen Pract 1992*; **42**: 415-418.

Postgraduate education

Sir,
We would like to respond to Dr Fox's criticism (May *Journal*, p.218) of our paper (January *Journal*, p.19). We were careful to report what the results showed and this was only that doctors who were members of a centrally organized educational scheme attended more educational meetings and that this applied for all categories of the postgraduate education allowance. Although we feel that the system is better educationally as it gives a more balanced spread of education we do not have the data to show this.

Dr Fox talks about education being a process whereby new skills and/or knowledge and/or attitudes are acquired which improve one's work and we could only agree with him. However, the literature on educational research in general practice is sparse. Fortunately this has been enhanced by the work from the west of Scotland. Dr Fox will be pleased to learn that we are currently looking at the effect of education on doctors in their day to day work.

T STUART MURRAY
G S DYKER
L M CAMPBELL

West of Scotland Committee for Postgraduate Medical Education
The University of Glasgow
Glasgow G12 8QQ

Quinine for night cramps

Sir,
In describing his crossover trial of quinine for night cramps (letters, March *Journal*, p.127) Dr Dunn states that 'this carry over effect suggests that withdrawal of quinine induces cramps. This is totally unexpected, and has not been reported before. Such an effect is difficult to explain.'

There were 14 patients in each group at the beginning of the trial, and a total of three dropped out. With such small groups it seems perfectly reasonable that the percentage of nights with cramp during the placebo period should be 65% in one group and 37% in the other. It only requires two or three individuals with severe symptoms to create this disparity.

If we look at the effect of quinine in each group we see that it reduced the incidence of nights with cramp from 65% to 27% in one group (58% reduction) and from 37% to 14% in the other group (62% reduction). This represents effective therapy in each group and in my opinion justifies the use of quinine for this condition.

DENIS CRADDOCK

36 Lackford Road
Chipstead, Surrey CR5 3TA

On-site physiotherapy

Sir,
Waiting list initiative money is being used in Doncaster to fund on-site physiotherapy in general practice. Twenty two of the 49 practices in Doncaster (45%) expressed an interest in establishing this service. Six practices have been funded to offer the service to their patients and Doncaster Health is keen to evaluate the initiative. Therefore Hackett and colleagues have produced a timely paper on the value of on-site physiotherapy in general practice (February *Journal*, p.61).

However, I am concerned about the different case mix in the three settings (one practice had on-site physiotherapy, one direct access and the third access only via orthopaedic consultants) and the fact that these were not taken into consideration in the analysis. The mix of diagnoses among patients in the practice with on-site physiotherapists differed significantly from that of the practice with access via orthopaedic consultants (chi square = 37.2, 7 degrees of freedom, $P<0.001$). On-site physiotherapy dealt with larger proportions of ankle ligament sprains and miscellaneous conditions and a smaller proportion of shoulder injuries. In particular, the higher proportion of prescriptions in the group with access only via a consultant may have been related to the case mix, thereby making the conclusion that ready access to physiotherapy may result in less drug prescribing a potentially misleading one?

The point made in the discussion that the practice with on-site physiotherapy had a rate of referral to physiotherapy of more than twice that of a practice with direct access is an extremely important one. Rates seemed higher for some conditions but particularly so for ankle ligament sprains and miscellaneous conditions. Beckerman and colleagues (February *Journal*, p.73) have demonstrated that there is as yet no proven benefit for treatment of many conditions with physiotherapy. It is not unusual to be undertaking