be identified by the patient's National Health Service number so it is not necessary to ask for the place of birth.

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Quality of general practitioner referrals to outpatient departments

Sir,

I read with interest the paper by Jenkins (March *Journal*, p.111) which further highlights areas of possible improvement in referral letters from general practitioners to hospital specialists.[1] The article focused primarily on medical and surgical specialties and I would like to complement Jenkins' findings with those from a recently reported study investigating the quality of referral letters from general practitioners to psychiatrists.[2]

Two hundred and seventy referrals were made during a two year period to a general psychiatric outpatient clinic, by 52 general practitioners. Baseline information of the patient's age and sex were included in almost all general practitioners' letters. The presenting complaint was mentioned in nearly all letters and the reason for referral in 87% of letters. Current medication was commented on in 68% of letters, which was a lower percentage than expected. Background information, such as family history, social circumstances and past illnesses, were not often mentioned.

The deficiencies found in referral letters from general practitioners to psychiatrists are, therefore, similar to those found by Jenkins in referral letters to medical and surgical specialties. Recommendations are required for improving the standard of general practitioner referral letters to all hospital specialties.

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2. Prasher VP, Fitzmaurice D, Krishnan VHR, Oyebode F. Communication between general practitioners and psychiatrists. *Psychiatr Bull* 1992; **16:** 468-469.

Automated external defibrillation

Sir,

Dr Colquhoun may be overestimating the potential for general practitioners to resuscitate their patients with an automated external defibrillator (editorial, March *Journal*, p.95). The Grampian region early anistreplase trial involved 29 practices (91 general practitioners) over 37 months.[1] Only 15 patients in the trial had a cardiac arrest before reaching hospital. Undoubtedly, further instances of cardiac arrest would have occurred in patients excluded from the trial, but the number of such cases was not stated. Nevertheless, the number of cardiac arrests per general practitioner was very small.

It would therefore seem unjustified for every general practice to have its own defibrillator as this would be rarely used. It would be much more sensible to use the defibrillator in the front line ambulance.

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Quinine for night cramps

Sir,

I found the report by Dr Dunn on the effectiveness of quinine for night cramps (letters, March *Journal*, p.127) most interesting. My own advice and treatment regimen, however, varies quite considerably but has proved successful, and I have never come across the phenomenon of withdrawal cramps described by Dunn.

As quinine sulphate is not easily available in Israel, I have prescribed quinidine bisulphate 200 mg tablets for the last 20 years. The patient is given a prescription for 20 tablets and advised to take one tablet within an hour of going to bed. Treatment is usually found to be beneficial within three days and a one week course is suggested. If there is no immediate benefit from the treatment the full course of 20 tablets is recommended. At the same time the patient is taught to exercise the flexor muscles of the calf for a gradually increasing period of up to one minute.

I have not carried out a randomized, double-blind, crossover study as described by Dr Dunn, but my regimen appears to work. Quinidine sulphate is a chemical isomer of quinine sulphate, and its action seems no different for the treatment of night cramps.

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Family planning services

Sir,

It is now 18 years since general practitioners began to receive item-of-service payments for the provision of family planning services to their women patients. At that time, at the conference of local medical committees, family doctors made it clear that they wanted to opt out of the prescription of condoms.

In 1993, most general practitioners in Exeter and the surrounding district think otherwise. A survey of 188 doctors has revealed that of the 140 who replied, 124 were in favour of being able to supply condoms free to their patients, 15 were against and one was uncertain. It may be that consideration of the risk of the acquired immune deficiency syndrome (AIDS) is responsible for this change.

The community family planning clinics are seeing record numbers of women and men who are choosing the condom as their main method of contraception (Exeter and District Community Health Service Trust, Annual report of the family planning service, 1993). In addition, the clinics are able to provide the recommended 'double Dutch' method of oral contraceptive pill and condom together, to those at risk of sexually transmitted diseases as well as pregnancy. Provision of both is essential if we are to tackle the challenges of the *Health of the nation.*[1]

It is time that general practitioners were also able to offer condoms, ensuring a comprehensive family planning service for all.

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