

Counselling <i>T N Stokes</i>	139	Treating nocturnal enuresis <i>David Seamark</i>	141	Estimating date of delivery <i>Simon Hill</i>	142
Prescribing generic drugs <i>J D Young</i>	139	Who will guard the guards themselves? <i>John Haworth</i>	141	Note to authors of letters: Please note that all letters submitted for publication should be typed with <i>double spacing</i> . Failure to comply with this may lead to delay in publication.	
Antenatal care project <i>R N Haworth</i>	140	Fears of HRT <i>I A H Barker</i>	141		
'Mobile' patients <i>A N Allan</i>	141	Diabetes care <i>R W McCallum</i>	142		

Counselling

Sir,

There has been much interest in the use of counselling in primary care.¹ The referral pattern of general practitioners to counsellors has been studied.² However, little is known of the views of general practitioners concerning counselling, what training general practitioners have received in counselling and the amount of counselling performed by them.³

In 1992, a questionnaire on counselling was sent to all 95 general practitioner principals in one Yorkshire health authority.

Of the 76 general practitioners who replied, 61 felt that the need for counselling to be provided in general practice was important, and 55 felt their own role in providing this was important.

Of the 69 doctors who gave a definition of counselling 30 defined it as 'listening' or 'helping', and 37 gave a more detailed definition of specific counselling skills being used in a non-directive exploration of the patient's problem. Two doctors gave a definition which equated counselling with psychotherapy. Forty had received training in counselling, 17 of whom had received supervision of individual cases.

Seventy one doctors reported undertaking counselling as part of their work. All but one provided patients with follow-up appointments to discuss their problems further, and eight made special arrangements within the practice to provide a counselling service. Sixty nine doctors identified lack of time and 34 lack of training as obstacles to providing more counselling.

All respondents referred patients to other agencies for counselling; 73 referred patients to a clinical psychologist, 67 to voluntary agencies, 65 to a community mental health centre and 50 to other members of the primary health care team.

Regarding voluntary agencies, 18 different local and national organizations were used. The most popular of these were 'Relate' marriage counselling service (used by 47 doctors), 'Cruse' bereavement care (19), and Alcoholics Anonymous/

Alcoholics Anonymous for relatives (eight).

Regarding the primary health care team, 30 doctors referred patients to a health visitor for counselling, 13 to a practice nurse, seven to a district nurse, five to a practice counsellor, four to a general practitioner partner offering psychosexual counselling, two to a community psychiatric nurse, one to a midwife and one to a Macmillan nurse.

All respondents referred patients with relationship problems for counselling, 73 referred patients with psychological problems, 66 referred patients with drug and alcohol problems and 60 referred bereaved patients.

This study was carried out in a health authority which has a high proportion of semi-rural and training practices and the results may not therefore be applicable to other areas. The majority of general practitioners were interested in counselling and thought it was an important part of general practice. However, nearly half had not received training in counselling, and almost all reported that lack of time prevented them from offering more counselling to their patients. There was frequent referral to other members of the primary health care team who should therefore be adequately trained in counselling. General practitioners varied in their use of other agencies, perhaps suggesting a need for more information about counselling services available outside the practice. Further research is needed on the effectiveness of these different counselling interventions. Counselling has important resource implications for general practice, especially given the increasing employment of counsellors by general practitioners.⁴

T N STOKES

66 Shaw Lane
Oxenhope
Keighley
West Yorkshire BD22 9QL

References

- Sheldon M (ed). *Counselling in general practice*. London: Royal College of General Practitioners, 1992.
- Thomas RVR, Comey RH. Working with community mental health professionals: a survey among general practitioners. *Br J Gen Pract* 1993; 43: 417-421.

- Comery R. Studies of the effectiveness of counselling in general practice. In: Comery R, Jenkins R (eds). *Counselling in general practice*. London: Routledge, 1993.

- Sibbald B, Addington-Hall J, Brennehan D, Freeling P. Counselling services on-site within English and Welsh general practices: their nature and distribution. *BMJ* 1993; 306: 29-33.

Prescribing generic drugs

Sir,

In recent years encouragement has been given to general practitioners to change from branded to generic prescribing.¹ There is no evidence, other than anecdotal, to support claims that generic products are inferior to proprietary drugs.² Despite this, it is often said that patients resist changing from a brand name drug which they know well to a generic equivalent which may look different. A study was undertaken to look at what would happen to prescribing patterns over a six month period when patients had their repeat prescriptions changed from brand name drugs to generic drugs.

The practice in which the study was carried out has nine partners and a list size of 24 000. The practice computer system was used to draw up a league table of potential savings to be made by changing certain brand name drugs to generic drugs, and two drugs each month were changed to their generic equivalent. One week before each pair of drugs was changed over, a memorandum was sent to all partners and staff reminding them which were the next two drugs to be changed. Patients did not receive prior notification but a note was attached to the first repeat prescription explaining that although the drug might look different it had not actually been changed.

At the end of six months the proportion of patients who had either changed back to the branded product or who had stopped the drug completely was compared with that for patients who were already receiving the generic version of the drug at the start of the trial. The drugs involved were Aldomet® (Merck Sharp and Dohme)/methyl dopa, Brufen® (Boots)/ibuprofen, Ventolin® (Allen and Hanburys)/salbuta-

mol, Tagamet® (Smith Kline and French)/cimetidine, Indocid® (Morson)/indomethacin, Tenormin® (Stuart)/atenolol, Lasix® (Hoechst)/frusemide, Inderal® (Zeneca)/propranolol, Moduretic® (Du Pont)/co-amilozide, Daonil® (Hoechst)/glibenclamide, Lanoxin® (Wellcome)/digoxin, Elantan® (Schwarz) and Monit® (Lorex)/isosorbide mononitrate.

A total of 1917 patients who had originally been prescribed a brand name drug were changed to the generic equivalent and 90.5% of these patients were still taking the generic drug six months later, 1.3% having gone back to the brand name drug and 8.2% having stopped taking the drug altogether. Of 1287 patients who were taking the generic drug at the start of the study 90.2% were still taking it six months later, the other 9.8% having stopped taking the drug completely.

The study found no evidence to support the belief that patients object to being changed from proprietary drugs with which they are familiar to generic products. Worthwhile savings to the National Health Service could be achieved by this method.

J D YOUNG

The Medical Centre
72-74 Medomsley Road
Consett
County Durham DH8 5HR

References

1. Anonymous. For and against generic prescribing. *Drug Ther Bull* 1987; 25: 93-95.
2. Anonymous. Generic prescribing. *MeReC Bull* 1991; 2: 21-24.

Antenatal care project

Sir,

It seems an opportune time to describe a current antenatal care project which started in November 1991. At the moment there is great controversy as to how often pregnant women should be seen, by whom, and which procedures ought to be carried out.¹ I reviewed available evidence²⁻⁴ and constructed a different model of care. This involved extensive consultations with the maternity department at Crawley District General Hospital; the maternity services liaison committee received regular reports of the ongoing project and the Medical Defence Union gave advice. Permission was given by the maternity services liaison committee for my practice, which has four doctors, one community midwife and 9000 patients, to carry out a pilot trial.

The main change was that the patients were divided at the first consultation into

two categories: 'low risk' and 'traditional risk'. 'Low risk' meant that no antenatal complications could be reasonably anticipated and these patients were seen much less often than they would have been under the existing system. As expected, the outcome of pregnancy could not be predicted, but no major problems arose during the trial. However, there was one case of iron deficient anaemia at delivery which had been missed because haemoglobin concentration had not been measured on the second occasion. Low risk primigravida patients did not normally attend the hospital until 36 weeks, except for an ultrasound scan. All decisions were made after considering check lists and discussions with the patient. Table 1 shows the schedule that was usually followed. The routine monitoring of weight gain and oedema were abandoned. Fundal

heights were measured; it is recognized that this has a 10% error rate at best but it is the only screening method in the community for intrauterine growth retardation.⁵ Normally, women who felt unwell and who were more than 20 weeks pregnant had their blood pressure measured within two hours of informing the practice.

Over six months, all 'low risk' women were given a questionnaire some time after the birth of their baby. The patients wholeheartedly approved of the new regime although they would all have liked to see a midwife more often. The surgery clinic has been changed from a conveyor belt environment to a series of leisurely consultations. Patients' worries are explored, tests explained and management agreed. Discussion with the doctors revealed that they found the new system

Table 1. Antenatal clinic attendance protocol.

Week	Low risk multipara ^a	Low risk primigravida ^b	'Traditional' risk women
8	Book in, take blood sample and see GP	Book in, take blood sample and see GP	Book in, take blood sample and see GP
12	Book on practice computer by midwife	Book on practice computer by midwife	Book on hospital computer by midwife
16	AFP test — see practice nurse Nurse check MSU result Any worries — see next clinic	AFP test — see practice nurse Nurse check MSU result	Hospital + AFP test practice
18/19	Ultrasound at hospital	Ultrasound at hospital	Ultrasound at hospital
20	GP/midwife (2 weeks after scan)	GP/midwife (2 weeks after scan) to make 36 week appointment at hospital	GP/midwife
24	Rhesus test if rhesus negative (practice nurse)	Rhesus test if rhesus negative (GP/midwife)	Rhesus test if rhesus negative
28	—	GP/midwife	GP/midwife
30	GP/midwife Repeat Hb and/or rhesus factor	—	GP/midwife Repeat Hb and/or rhesus factor
32	—	GP/midwife Hb and/or rhesus factor	Hospital
33	GP/midwife	—	—
34	—	GP/midwife	GP/midwife
35	GP/midwife	Consultant/hospital	Hospital
37	—	—	GP/midwife
38	—	GP/midwife	GP/midwife
39	—	—	GP/midwife
40	GP/midwife	GP/midwife	GP/midwife
41	(Variable)	Hospital	Hospital

AFP = alphafetoprotein. MSU = mid-stream urine sample. ^aIncludes low risk primipara. ^bIncludes women who have had terminations as these do not normally affect antenatal care.