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.

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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 evidence[2-4] 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. [a]Includes low risk primipara. [b]Includes women who have had terminations as these do not normally affect antenatal care.

stressful at first but in fact seemed to focus better on problems when they arose although the population profile did not allow a controlled trial.

Responsibility for routine care and assessment of risk status is now jointly shared between the general practitioner and midwife. The protocols are continuously updated and the main principles of this project, now taking the Winterton report[6] into account, are to be introduced into practices in Crawley and Horsham next year.

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'Mobile' patients

Sir,

The new contract for general practitioners included among its requirements that all new patients accepted or assigned to a list after 1 April 1990 should be offered a consultation to render personal medical services to the patient. Furthermore, specific details were required concerning past and present medical history, social and lifestyle factors, and health screening tests. In order to facilitate this process a revised 'new patient questionnaire' was developed for use in my practice of five partners, serving a population of 9950 patients.

A total of 103 new patients joined and left my practice in the first three years of this scheme. The information these clients provided on their questionnaire was analysed to assess the characteristics of this group of 'mobile' patients and their specific health needs.

Of the 103 'mobile' patients 50% were aged 16–25 years, 55% were women, 65% of 94 respondents were single, divorced, separated or widowed, and 45% of 94 respondents were unemployed. Almost half of these patients (43) smoked tobacco, one fifth (20) were obese,[1] and approximately one third (30) took no form of exercise. Six patients admitted to excess alcohol consumption (more than 14 units per week for women and more than 21 per week for men) and two reported having abused drugs at some time. Twenty four had some degree of significant past medical history and over one third (38) were currently taking prescribed medication, most commonly the oral contraceptive pill.

One third of the patients (33) did not know if they required a tetanus immunization booster and over one half (58) were unaware of their poliomyelitis immunization status. One third of the women (19) did not know the date of their last cervical smear. Other important details such as rubella and rhesus status are not requested on the questionnaire.

It is possible to obtain useful information from this type of questionnaire. However, these patients represent a significant recurring workload within general practice, both administratively in assessing their current medical needs, and clinically to provide appropriate preventive and ongoing medical care. Their mobility may prevent them obtaining optimal care and make it difficult to achieve both practice based and *Health of the nation* targets. Additional administrative and clinical facilities may be needed for this small but important group, possibly including alternative medical records for which the client is responsible.

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Reference

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Treating nocturnal enuresis

Sir,

O'Dowd makes an admirable attempt to review the management of urinary incontinence in women (October *Journal,* p.426). However, he has not referred to the role of vasopressin analogues in the management of primary nocturnal enuresis. In patients for whom other causes of nocturnal enuresis have been excluded, the use of desmopressin via nasal spray or intranasal solution can prove to be revolutionary. The treatment must be used in accordance with data sheet instructions, and regular review with attempted withdrawal after three months is essential.

Within the boundaries described, the use of desmopressin has made a considerable improvement in the quality of life of a number of my patients and should be mentioned in a review of urinary incontinence in women.

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Who will guard the guards themselves?

Sir,

I feel that Adrian Elliot-Smith (letters, November *Journal,* p.485) would be more usefully occupied if he complained about the parlous state of the National Health Service rather than grumbling about whether the president of the Royal College of General Practitioners should, in this learned journal, give the title his editorial in Latin.[1] The translation of this is already well known as it is a phrase of some note.

He grumbles about Latin being used as a 'secret code' between health professionals that alienates patients. Has he, for example, tried translating polymyalgia rheumatica into English?

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Fears of HRT

Sir,

The paper by Sinclair and colleagues (September *Journal,* p.365) debates the question of why more women who would benefit from hormone replacement therapy do not take up the offer of treatment.

From my experience the fear of breast cancer, not mentioned in this paper, is still the main cause of worry in a world where postmenopausal women all have friends and relations among the one in 12 who suffer from this disease. Reassurance that the incidence does not increase until at least five if not 10 years of treatment with hormone replacement therapy does not fully dispel the fear of increasing the risk of such a problem. Only continuing publicity from all sources will change this attitude.

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