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Abnormal menstrual bleeding in perimenopausal women

Sir,

Irregular menstrual bleeding and menorrhagia occur frequently among perimenopausal women¹ and are common reasons for consultation with a general practitioner.² Recommendations from specialists are that any woman over the age of 40 years with menorrhagia or other forms of increased vaginal bleeding should undergo endometrial biopsy in order to detect atypical endometrial hyperplasia and endometrial carcinoma.³ The incidence of malignant neoplasms of the uterus increases rapidly in women over the age of 40 years.⁴ A study was undertaken to investigate the frequency with which general practitioners refer women over this age who present with a new episode of abnormal menstrual bleeding.

The study involved 11 general practitioners in four surgeries. All the practices were fully computerized and contributed research data to one of two bodies (VAMP research or the Royal College of General Practitioners weekly returns unit). Women aged over 40 years who had consulted a general practitioner with abnormal menstrual bleeding were identified by a computer search of their records. Computer records and written records were then analysed.

The study was designed to observe the management of new episodes. Women who had consulted before full computerization of the practices and/or who had first consulted when aged 40 years or less were excluded. In addition, women who had had a hysterectomy, were postmenopausal, had consulted only with postoperative bleeding or pregnancy-related bleeding and those that had undergone endometrial biopsy within the previous three years were also excluded. In order to ensure adequate follow up, women with a new episode within nine months of the search were excluded and therefore so were women referred more than nine months after the onset of the new episode.

The diagnosis classification system used by the computer contains 28 terms which may involve increased menstrual bleeding. Some of these terms are specific, reflecting excess menstrual loss (for example, menorrhagia) and others are non-specific (for example, dysfunctional uterine bleeding). The diagnoses were divided into four groups. Of 110 women with excess menstrual loss, 38 (34.5%) were referred to a consultant gynaecologist; of 28 women with irregular menstrual loss, six (21.4%) were referred; of 15 women with intermenstrual loss, 10 (66.7%) were referred; and of 41 women with non-specific loss, 12 were referred (29.3%).

The rationale for endometrial biopsy in menopausal women who complain of abnormal menstrual loss is to detect endometrial abnormality yet only 34.0% (confidence interval 27.3%–40.7%) of such women were referred by their general practitioners.

If endometrial carcinoma is to be detected earlier then it would appear that either general practitioners need to refer more often and quickly or there needs to be more specific criteria for referral which reflect the issues within primary care. The new devices for endometrial sampling⁵ may provide a means of performing endometrial biopsy in general practice according to current specialist recommendations.⁶ The cost effectiveness of each approach needs to be evaluated.

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Non-attenders for cervical screening

Sir,

Although the achievement of cervical smear targets has been part of general practitioners' workload for some years, it is useful to examine the reasons why some women do not attend for screening.

Immediately prior to recent media scares concerning the taking of cervical smears,¹ a survey of call and recall non-attenders was carried out in a semi-rural practice with two men general practitioners. Although the practice achieves the higher uptake target (80%), it has a considerable group of non-respondents to requests to attend screening sessions.

An anonymous, postal questionnaire, sent to patients' homes with a stamped, addressed reply envelope, was used so that patients responding to the questionnaire could not be followed up. More than half of the 77 patients surveyed (53%) replied. In common with previous studies² reasons for non-attendance included a stated preference for the smear to be taken by a woman (24 respondents), and fear generated by the perceived lengthy waiting period for results (mentioned by six women). However, there were two other important findings.

Seven of the women reported feeling pressurized to attend for cervical screening in some instances to a degree where they were actively avoiding their doctor. Although the group considered themselves to be well informed on the importance of the smear test, three quarters (31 women) responded positively to a question offering their removal from the recall register until they themselves requested to be reinstated.

The study involved a small number of women. However, more than half of the group not responding to cervical screening requests were prepared to complete the questionnaire and return it to the practice and their replies to the questionnaire raise important issues. Where does health promotion end and undue pressure begin? Does the fact that doctors receive cervical screening target payments lead to the pressurization of patients? How would allowing a group of non-respondent to opt out of the programme affect such target payments? As there is a direct relationship between a regular cervical smear programme and reduced mortality from invasive cervical neoplasia,^{3,4} what are the ethical considerations in allowing vulnerable women to opt out?

It would be valuable to learn whether these feelings are present in non-attenders at cervical smear programmes in other practices and whether or not the more

recent media scares have had an adverse effect.

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Consultants' health

Sir,

The health of doctors has always interested me. When I heard Richards talk about his survey of 431 general practitioners in Avon¹ I wondered if consultants fared any better in their use of health care services. Richards found that general practitioners often prescribed for themselves, did not seek preventive health care and often felt their status as a doctor prevented them from discussing problems. With permission I sent Richards' questionnaire to all 53 consultants who worked in South Warwickshire District Health Authority in 1992. All questionnaires were anonymous and were returned to my home address. This ensured an identical method of data collection so the results of the two studies could be compared using the chi square test.

A total of 48 questionnaires were returned (91% response rate, similar to the 86% obtained in the Avon study). Of the consultants 92% were registered with a general practitioner (96% of Avon general practitioners); 40% of the consultants consulted a doctor more than once a year (25% of Avon general practitioners); 60% of the 48 consultants saw their general practitioner, 27% had arranged a consultant self-referral and 15% saw colleagues informally (no figures available from the Avon survey).

Questions were asked about self-prescribing of prescription-only medicines. The only significant difference between consultants and general practitioners was in antibiotic use: 82% of 431 general practitioners in the Avon study prescribed themselves antibiotics compared with 63% of the 48 consultants ($\chi^2=8.7$, 1 df, $P<0.01$). If seeking advice about specific complaints, more consultants than general practitioners would self-refer directly to a consultant about a suspicious lump (54% versus 25%)

or glycosuria (35% versus 15%, respectively) (both $P<0.01$). No consultants would seek advice from a consultant for sexual problems or drug dependence compared with 12% ($P<0.05$) and 17% ($P<0.01$) of general practitioners, respectively. In all other clinical problems posed there was no statistically significant difference between the two groups of doctors.

There was no significant statistical difference between the two groups in the poor rate of seeking preventive health care, that is blood pressure, smoking and drinking habits, stress or weight and diet. Of consultants 12% felt that their status as a doctor prevented discussion of problems compared with 23% of general practitioners (difference not statistically significant).

There is little difference between general practitioners and consultants in their use of health care services. In both groups self-prescribing rates are high, uptake of preventive care is poor and a measurable proportion feel isolated because of their status as a doctor.

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Continuity of care

Sir,

Freeman and Richards, in their paper on the compatibility of a free choice of doctor with personal continuity of care (December *Journal*, p.493), compared the care provided to patients in three different practices. As a result of a practice merger I have been able to study the priority attached to personal care by one group of patients offered two different styles of care.

In March 1991 our two man partnership, which encouraged a personal list system joined with our neighbouring five doctor practice which had three women partners. After the merger patients were given a free choice of doctor.

The proportion of consultations with the author in the calendar year before that merger (1990) and in the first full calendar year afterwards (1992) was determined from the case notes for the following groups of patients — at least 10 male or female patients aged three, five and 15 years in 1990, and for each sex aged 25,35,45,55,65 and 75 years in 1990 (Table 1). To select the notes the practice

computer printed the names of all patients registered with the author in the relevant years of birth. The notes for those years, and if necessary for the neighbouring years, were reviewed (rejecting any that joined the practice in or after 1990 and those who had not seen a doctor in the years in question) aiming to obtain at least 10 sets of notes of patients who could have seen the author in the year before and after the merger. There was a general fall in personal continuity of care following the merger which was particularly marked in children and young women.

The patients in the original two partner practice had experienced high levels of continuity of care without, I feel, experiencing much discontent. However, when offered a wider choice in the new practice they did not always think it worthwhile preserving such a close link. This was particularly true for the younger children and also for young women who presumably availed themselves of the opportunity of seeing a woman doctor.

Practices may do what they can about improving the availability of their doctors, but the doctor's sex is one unalterable influence on the feelings of his or her patients about continuity of care.

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Table 1. Percentage of consultations with the author before and after the practice merger.

Age in 1990 (years)	% of consultations with author	
	1990	1992
<i>Children</i>		
3 (n = 31/51)	77	49
5 (n = 34/24)	68	50
15 (n = 12/8)	92	75
<i>Women</i>		
25 (n = 48/50)	88	26
35 (n = 27/27)	81	48
45 (n = 32/39)	88	69
55 (n = 35/36)	97	81
65 (n = 76/76)	83	66
75 (n = 44/53)	95	70
<i>Men</i>		
25 (n = 25/68)	96	79
35 (n = 23/43)	83	74
45 (n = 25/30)	92	60
55 (n = 17/36)	100	69
65 (n = 34/44)	94	80
75 (n = 72/69)	89	77

n = total number of consultations in each group in 1990/1992.