increased incidence of pre-term delivery, fetal distress and of stillbirth.[2,3]

A mother will often relate her symptoms to the first professional carer with whom she is in contact, and, if they are played down, will not mention them again. It would be good practice for all professionals to ask directly. The condition may, however, be clinically obvious when the mother attends her antenatal visit with visible scratch marks on her legs.

As a consultant obstetrician, I have personally known five mothers whose obstetrician/midwife/general practitioner had been unaware of the potential hazard of this condition and these mothers had six stillbirths between them. Four have had a subsequent pregnancy in which they again developed obstetric cholestasis, but delivery prior to 38 weeks gestation achieved a live child. Another mother in whom cholestasis was diagnosed had a sister with similar symptomatology who had suffered two 'unexplained' stillbirths. A mother with proven obstetric cholestasis must be regarded as having a high risk pregnancy and thus additional monitoring must be instituted and the pregnancy ended by 38 weeks gestation.

Various drug treatments have been tried to treat obstetric cholestasis and the present drug of choice would appear to be ursodeoxycholic acid given orally, up to 750 mg per day throughout pregnancy. This drug stops the puritis and reduces serum levels of bile acids and liver enzymes.[4] Loss of control of the symptoms would be an indication to deliver the baby early. Ursodeoxycholic acid is thought to act by replacing more cytotoxic bile salts (possibly linoleic acid) in the bile acid pool. Unfortunately, it is not licensed for use in pregnancy and therefore can only be used on a named patient basis with her understanding and consent. At present it would be difficult to be certain that it definitely protects the fetus from unexpected probable biochemical death.

A more widespread understanding of the potential risk of obstetric cholestasis is of even greater importance as obstetric/midwifery practice changes with the implementation of the Cumberledge report.[5] This means that mothers who are judged to be 'low risk' will not necessarily have any obstetricians involved in their antenatal care and all deviations from normal will be expected to be detected in the primary care setting.

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General practice–psychiatry liaison by audioconference

Sir,

With the National Health Service reforms and the development of community oriented psychiatric services, improved communication between general practitioners and specialists is of paramount importance.[1] Audioconferencing provides a new method of communicating. The procedure involves a moderator, present in one location and several other participants located in different places, all linked together by telephone.

In February 1994, a small study was carried out to evaluate an audioconference between a psychiatrist and four local general practitioners. Two of the general practitioners were men and two women. Two had no previous experience of audioconferencing and two had minimal experience. The psychiatrist (a man) had no previous experience of audioconferencing.

A detailed agenda was sent to each participant one week before the meeting. The topic chosen for discussion was community psychiatry and the planned duration of the conference was 55 minutes. For the audioconference the psychiatrist and two hospital representatives were based in a private hospital facility. The general practitioners were in their surgeries. The technical equipment needed was a voicepoint, provided by a communications company. A voicepoint is like a hands-free telephone set and one speaks at it from a distance of about three feet. It is voice-activated which means that only one person can speak at a time. To speak, one has to interject after the previous speaker has finished or during a pause. The hospital-based participants used the voicepoint and the general practitioners used their standard telephones.

The conference began at 12.30 hours when the psychiatrist contacted the telephone operator and the operator then contacted the general practitioners. The psychiatrist invited each general practitioner to speak in turn. An interactive discussion followed.

Each general practitioner was interviewed by a hospital representative, using a semi-structured interview devised by the psychiatrist, within one week of the conference. The method of audioconferencing was generally acceptable to the general practitioners. The main advantages were considered to be networking with colleagues, convenience, reduced travel and savings including time and money, but these were not quantified. The problems identified were technological difficulties including staccato speech and poor sound quality. All the general practitioners felt extra concentration was required owing to the lack of non-verbal cues and unfamiliarity with the technology. Three general practitioners indicated a preference for an additional visual component (that is, seeing a face).

Two general practitioners were satisfied with the timing of the conference and two dissatisfied. Evenings were chosen as the most convenient time by two general practitioners, lunchtime by one and before afternoon surgery by one. The surgery was seen as the most convenient place to participate in a conference by all the general practitioners.

Three general practitioners recommended improved sound and visual aids, and one general practitioner recommended having a microphone or hands-free telephone rather than a hand-held telephone.

Future uses for audioconferencing were suggested: giving general practitioners who do not attend meetings the opportunity to participate in an interactive discussion from their surgeries or homes; enlisting prominent distant speakers; holding seminars with postgraduate education accreditation approval so that doctors living in remote areas would not be disadvantaged regarding their continuing medical education; and running section 117 meetings (section 117 refers to the statutory duty of trusts/NHS hospitals to provide aftercare for patients detained in hospital under sections 3, 37, 41, 47 and 48 of the mental health act 1983).

When asked if they would participate in further meetings, one general practitioner replied no, one probably and two yes. Further evaluation of audioconferencing is warranted.

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Emergency contraception

Sir,

The paper by Julie George and colleagues