The Family Planning Association leaflets are excellent, giving accurate advice and a balanced picture of the health implications of taking hormonal contraceptives.

Smith and Whitfield's study perhaps confirms our fears that even if a patient has been given an information leaflet, she will probably still not take the correct measures if she were to miss the pill.

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References

1. Metson D, Kassianos GC, Norman DP, Moriarty J. Effect of information leaflets on longterm recall — useful or useless? *Br J Fam Plann* 1991; **17:** 21-23.
2. Metson D. Lessons from an audit of unplanned pregnancies. *BMJ* 1988; **297:** 904-906.

Diphtheria

Sir,

I read with interest Martin's editorial on diphtheria (August *Journal,* p.394), which gave an excellent summary of its epidemiology, management and prevention. The current epidemic in the countries of the former Union of Soviet Socialist Republics (USSR), together with the increased travel to that part of the world, has certainly refocused attention on this potentially fatal infectious disease. I have a number of points to add to those stated in the editorial.

First, general practitioners will be interested to know that a single antigen diphtheria vaccine for adults is available. Although the combined adult diphtheria/tetanus vaccine is usually an acceptable alternative for adults requiring diphtheria immunization, it cannot be administered to patients who have had a previous severe reaction to tetanus immunization.

Martin stated that all close contacts of patients with diphtheria should be prescribed antibiotic prophylaxis, without waiting for their swab results and irrespective of their vaccine status. Although I tend to agree with the author, it is worth pointing out that others have argued that only those close contacts who are inadequately immunized or who have positive swab results should receive prophylaxis.[1,2] It is also useful to define who should be considered a close contact. The list includes: household members, friends/relatives/carers who regularly visit the home, kissing/sexual contacts, school classroom contacts, those who share the room at work and health care staff exposed to oropharyngeal secretions of the patient.[3] These close contacts should be kept under daily surveillance for at least seven days after the last contact with the patient. Surveillance should include inspection of the throat for the presence of a membrane and measurement of temperature.[3] Contacts should be considered clear when a minimum of two negative nose and throat swabs have been obtained, at least 24 hours apart, beginning at least seven days after the last contact with the case or carrier and at least five days after completion of any antibiotic prophylaxis.[1] Close contacts whose swabs are positive should be excluded from handling food and from work with schoolchildren until bacteriological clearance is obtained.

The World Health Organization has recommended that coverage levels should exceed 95% of infants receiving three diphtheria immunizations by the age of two years.[3] However, like many other historically important infections, there is a danger that the rarity of diphtheria in the United Kingdom could lead to complacency. Therefore, the importance of public education on the need for immunization (both routine and travel-related) cannot be over-emphasized.

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References

1. Emond B. *Infection.* Oxford: Blackwell Scientific Publications, 1989: 57-60.
2. Benenson A. *Control of communicable diseases in man.* Washington, DC: American Public Health Association, 1990.
3. Begg N. *Diphtheria — manual for the management and control of diphtheria in the European region.* Copenhagen, Denmark: World Health Organization, 1994.

Practice nurse workload

Sir,

In their paper on practice nurses' workload and consultation patterns (August *Journal,* p.415) Jeffreys and colleagues raised some interesting issues, but I felt that the study was too focused on the tasks performed rather than considering all aspects of a patient's needs.

In my own research, as yet unpublished, I audiotape recorded practice nurse consultations and subsequently analysed them, attempting to replicate the work of Byrne and Long.[1] The 'task', for example the dressing of a wound or the taking of a blood sample, proved to be the pivot or focus of the consultation with nine other categories of intervention interwoven throughout. The most frequently occurring were: education and explanation; building the patient–nurse relationship; and health promotion.

The practice nurse, because of experience and extended training, is able to make assessments of a patient, understand the clinical significance of findings and when necessary seek appropriate medical advice for the patient or refer to other professionals. It is these elements which I believe contribute greatly to the quality of patient care and might be lacking if a health care assistant were to undertake some of these aspects of patient care, as proposed in the paper by Jeffreys and colleagues.

Delegation of form filling, patient recall systems, computer skills and routine clerical tasks would be more appropriately undertaken by non-medical staff. I envisage practice nurse teams comprising a mix of skills with different levels of training, interests and clinical skills, more integrated with community nurse colleagues, and also continuing to share with general practitioners the care of patients with diseases such as asthma, diabetes and hypertension.

I am sure that it is right to look at the practice nurse workload and delegate wherever possible to appropriately trained personnel, although I have reservations about the employment of health care assistants to perform tasks such as blood sampling and blood pressure measurement.

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Reference

1. Byrne P, Long B. *Doctors talking to patients.* London: Royal College of General Practitioners, 1976.

Re-education via Darwinian medicine

Sir,

Medical teaching would be revolutionized if greater attention were paid to Darwinian