more research into the National Health Service reforms, including the effect of fundholding on transaction costs, equity and quality of care (particularly for patients of non-fundholding general practitioners). To some extent, fundholding has curbed the upward trend in prescribing costs and has given general practitioners leverage in improving access to hospital services for their patients. So far, there appears to be no evidence that fundholding has improved the quality of secondary care.

In New Zealand, there are concerns about the dominance of the hospitals and the lack of any real credence being given to the notion of primary-care-led reforms. In both countries, underfunding of both primary and secondary care means that the achievement of many of the goals of the reforms will be slow. Perverse incentives driven by the purchaser–provider split exist in both systems and need to be fully understood and their impact quantified.[6] Cost containment is a key theme and little attention has been given to the quality of care delivered so far.

There is a clear need to evaluate the effects of the reforms in both countries. It is imperative that governments commit substantial funding to research the changes being brought about by the health reforms. Potentially, there could be much to learn from research comparing the performance of the two similar but different systems.

GREGOR COSTER
Professor of General Practice, School of Medicine, University of Auckland, Auckland, New Zealand

PAULINE MCAVOY
Medical Director, Newcastle City Health Trust, Newcastle upon Tyne

References

1. Ministry of Health. *Your health and the public health.* Green and White Paper. Wellington: Ministry of Health, 1991.
2. Mason A, Morgan K. Purchaser–provider: the international dimension. *BMJ* 1995; **310:** 231-235
3. Ministry of Health. Statement. Wellington: Ministry of Health, 1996.
4. National Advisory Committee on Core Health and Disability Support Services. *Fourth annual report.* Wellington: National Advisory Committee on Core Health and Disability Support Services, 1995.
5. Dixon J, Glennerster H. What do we know about fundholding in general practice? *BMJ* 1995; **311:** 727-730.
6. Paton C. Present dangers and future threats; some perverse incentives in the NHS reforms. *BMJ* 1995; **310:** 1245-1248.

Address for correspondence
Dr Pauline McAvoy, Medical Director, Milvain Building, Newcastle General Hospital, Westgate Road, Newcastle upon Tyne NE4 6BE.

Some dilemmas in managing gynaecological infections

Asking patients for their views on what their symptoms mean, and on what they would like done about them, can resolve as many difficulties in the individual consultations[1] as it can be useful as a research question. In this month's *Journal,* O'Dowd and colleagues provide an example of this usefulness in their report on women's experiences of the management of vaginal symptoms.[2] Nearly 90% of the women either believed their symptoms to be sexually transmitted or suspected that they might be. Partners developed symptoms in a quarter of the cases. One-third of the women had bought over-the-counter (OTC) medicines. Whether or not a vaginal examination was performed was not influenced by the gender of the doctor, a finding similar to that reported by Coulter *et al* in their study of menorrhagia, when men and women general practitioners managed the condition similarly.[3]

O'Dowd *et al* report a high level of recurrence of symptoms, with 85% of women having previous episodes of vaginitis, and one-third reporting three or more attacks in the past year. Out of the patients with previous episodes, two-thirds said they consulted the doctor with every recurrence. As the authors comment, the study methodology may have led to the selection of a sub-group of patients: those who have both recurrent symptoms and a belief in the benefit of a medical approach. This is relevant when analysing the study's suggestion that an appropriate clinical standard would be for every patient with vaginal symptoms to receive the offer of a vaginal examination in a practice equipped with the knowledge and skills to diagnose and manage vaginal infections, since this suggestion may then be best applied to those patients who have recurrent symptoms.

This recommendation from O'Dowd *et al's* study also raises a number of issues common to many other clinical conditions managed in general practice. These issues include the need for improved predictive information on symptoms and signs to enable general practitioners to identify more quickly those patients with serious disease from those with minor self-limiting conditions, net-working with secondary care services on medical advances and developing a strategy for managing the workload and time implications as the clinical direction of primary care evolves.

Approximately 5% of women present to their general practitioner every year with a new problem associated with a gynaecological infection or related symptoms.[4] A small number of these women will have a potentially serious infection, such as *Chlamydia trachomatis,* which requires investigation and treatment. Others will have minor, self-limiting conditions best managed by advice and OTC preparations. As always, the general practitioner's dilemma is in deciding which patient falls into which category. A recent review of chlamydial infection in general practice recommended that chlamydia testing should be offered to women requesting a termination of pregnancy and to those who have the following risk factors: less than 25 years of age; absence of barrier contraceptions; a recent change of sexual partner; vaginal discharge; or sterile pyuria.[5] But how accurate are these risk factors in primary care? If we restrict investigation to these patients, how many with serious disease will we miss? And are we going to over-investigate those women presenting with vaginal symptoms who have a fungal infection, especially if thrush is the gynaecological equivalent of the viral URTI? The best way to answer these questions is with a coordinated programme of research in a number of practice populations, giving general practitioners regular, updated information on the changing prevalences of gynaecological infections, and the predictive value of symptoms and signs.

Communication between primary care and genito-urinary medicine clinics is limited. Because of the position taken by genito-urinary medicine clinics on patient confidentiality, general practitioners rarely receive out-patient letters detailing the investigation and management of their patients. This removes a useful source

of information for general practitioners on current management issues in patients with gynaecological infections; for example, contact tracing and HIV testing. Clinical communication between general practitioners and genito-urinary medicine clinics needs to be improved, perhaps by regular bulletins from each genito-urinary clinic to their local general practitioners on how they currently investigate and manage patients, infection prevalences and co-existing pathogen rates, for example.

The clinical direction taken by general practice will need to evolve with changing patterns of disease, medical advances and alterations in patients' expectations. What is not clear is the strategy primary care has for dealing with the workload implications of such changes. For example, O'Dowd and colleagues' suggestion that every patient with vaginal symptoms should be offered a vaginal examination has time implications that most general practitioners will recognize only too well. A recent qualitative study of general practitioners has identified time pressure as an important source of stress.[6] Unfortunately, experience to date suggests that increased workload in primary care is not accompanied by more resources. Therefore, it is difficult to see how new or increased services are to continue to be introduced into primary care without corresponding disinvestment in some other services currently being provided by general practitioner. Priority setting in primary care has to be debated.[7]

In O'Dowd *et al's* study, the role of the practice nurse was limited, with 2% of the patients choosing to see the practice nurse. In a recent survey of practice nurses' workload and consultations patterns, 9% of nurse procedures were in the diagnosis and management tasks category,[8] and the authors suggested that there is scope to reallocate responsibilities within the primary care health care team. Also, if more vaginal examinations are carried out in primary care, it could be argued that chaperones may need to be used more often.

As with many other clinical aspects of general practice, the management of women with vaginal symptoms presents a number of dilemmas. More diagnostic information, improved communication with specialist care and planning of service developments have been identified as some of the issues for debate.

PENNY OWEN
Llanedeyrn Health Centre, Cardiff

References

1. Arborelius E, Bremberg S. What can doctors do to achieve a successful consultation? Video-taped interviews analysed by the 'consultation map' method. *Fam Pract* 1992; **9:** 61-66.
2. O'Dowd TC, Parker S, Kelly A. Women's experience of general practitioner management of their vaginal symptoms. *Br J Gen Pract* 1996; **46:** 415-418.
3. Coulter A, Peto V, Doll M. Influence of sex of general practitioner on management of menorrhagia. *Br J Gen Pract* 1995; **45:** 471-475.
4. Royal College of General Practitioners, Office of Population Censuses, and Department of Health. *Morbidity statistics from general practice. Fourth national study,* 1991-92. London: HMSO, 1995.
5. Oakeshott P, Hay P. General practice update: chlamydia infection in women. *Br J Gen Pract* 1995; **45:** 615-620.
6. Rout U. Stress among general practitioners and their spouses: a qualitative study. *Br Gen Pract* 1996; **46:** 157-160.
7. McMee M, Figueras J. Setting priorities: can Britain learn from Sweden? *BMJ* 1996; **312:** 691-694.
8. Jeffreys LA, Clark AI, Koperski M. Practice nurses' workload and consultation patterns. *Br J Gen Pract* 1995; **45:** 415-418.

Address for correspondence

Dr Penny Owen, Llanedeyrn Health Centre, Maelfa, Llanedeyrn, Cardiff CF3 7PN.