general practice ultrasound in predicting fetal survival to the twentieth week of pregnancy, following early pregnancy bleeding. The paper would have been more useful to practising GPs if the predictive value of such ultrasound had been given by age at the first bleed. Indeed, we do not even know the distribution of gestations at which bleeding occurred. Were 90% of women less than 12 weeks gestation? Were half of them over 16? Secondly, once women had bled, were they only referred if there was an absence of fetal heart sounds after using only the ear trumpet, or after absence of sounds found using a sonic aid? This is a crucial point because once the fetal heart has been heard using a sonic aid after an early pregnancy bleed, there can be little point in following it up with an ultrasound as advocated in this paper.

More importantly, the whole paper may be based on false assumptions. In the 'Discussion', the authors state that, before the development of ultrasound scanning, 'bed rest was frequently advised for women with viable and non-viable pregnancies without discrimination'. Therefore, the implication is that, if a scan is done, one could avoid unnecessary bed rest. The flaw in this argument is that there is no evidence that bed rest makes any difference to threatened miscarriage. Therefore, it should not be advocated at all as a routine. Women should be told that there is no evidence that it will make any difference to the outcome of the pregnancy and then choose whether they wish to rest or not.

The other potentially falacious reason for using ultrasound in this situation is that, if the fetus is not alive, then 'appropriate arrangements can be made at an early stage in the knowledge that miscarriage is inevitable'. The implication here is that an ERPC could be arranged without unnecessary delay. This assumes that ERPC is of benefit to women with inevitable or incomplete miscarriage. This may well not be the case. A recent Swedish trial found that ERPC versus expectant management did not improve outcome and may have increased infection.[1] Indeed, the Dutch College of General Practitioners[2] recommends that a scan is delayed for up to 2 weeks with no increased in complications. Such a waiting policy will avoid most ERPCs at present performed in the UK. However, unlike Dutch women, British women may not accept such a delay. Certainly, the authors do not discuss this point.

The authors finally suggest that 'further studies are needed to compare the different ways of delivering a prompt, diagnostic ultrasound service for all women with bleeding in early pregnancy'. The real question surely is whether an ultrasound is necessary at all? Research is required into women's views towards the use of ultrasound in early pregnancy bleeding, and into the best way of managing confirmed, inevitable or incomplete miscarriage.

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Guidance for GPs for Maternity Medical Services

Sir,

I am writing to express my concern over the Guidance for GPs for Maternity Medical Services, which was distributed by the GMSC in November 1995.

The document claims to try to protect women who choose GP-managed obstetric care, whether it be a home delivery, a GP unit or GP/consultant integrated unit, from suffering as a result of being attended by a GP who does not possess specialist obstetric skills by recommending that no GP should undertake intrapartum care unless he or she possesses such skills.

If the recommendations in this report are accepted, then women who wish to exercise their right to choose a home birth are much less likely than they are at present to be able to find a GP willing to attend, GP units will cease to exist, and midwives, who have no choice but to attend home births, will find their workload increasing.

Most women are aware that their GP usually does not have specialist obstetric skills, and it is reasonable to presume that they take this into account when making a decision about their delivery.

To recommend that a GP should withdraw his or her services from a patient, and thereby, reduce the range of delivery options available, when both are fully aware of what level of skill the GP can offer, is to act in a way which is contrary to the stated aim of *Changing Childbirth.*

If I had a patient with ischaemic heart disease who declined the offer of a consultation with a cardiologist, should I then refuse to treat her on the grounds that from then on I might expect my treatment of her to be judged by different and higher standards?

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Postnatal sexual health

Sir,

There is a widespread clinical impression that the period following childbirth is a common time for the onset of sexual problems,[1] and the NCT-commissioned study supports this view.[2]

Barret and Victor[2] suggest that GPs can begin to address the problem by asking simple direct questions, and in our experience, we fully endorse this. However, we think that GPs can do more than inform women of the negative effect that breast feeding may have on libido.

Childbirth, though a single event, is associated with enormous life changes that affect a couple not just for months but for years afterwards. The main contributing factors are hormonal changes, physical changes including intrapartum trauma, emotional and psychological changes in the woman and the man, and a significant change to the couple dynamics in the case of the first child or family dynamics for subsequent children.

Studies on how couples cope with the transition to parenthood have generally shown this to be experienced as a crisis,[3] and that children have a negative effect on their parents' relationship.[4] Thus, the sexual problems that present to clinicians may just be markers of dysfunctional relationships.

We believe that the majority of sexual problems need to be treated within the context of the relationship. Many heterosexual relationships depend on sexual communication as the major channel through which couples share time, thoughts and emotions. When this intimate contact declines because of disinterest, exhaustion or both, emotional distance develops that makes meaningful talk a little harder than it used to be. There is often a reduction in the intimacy-promoting activities that subtly lubricate the wheels of communication, such as nights out, time alone together and sex.

General practitioners, health visitors, midwives and other health professionals who have contact with women (and couples) during pregnancy and the postnatal period would do well to consider the difficulties couples face, and be able to discuss not only the hormonal and physical changes, but the relationship changes as well.

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Chlamydia infection in women

Sir,

In their review article, Oakeshott and Hay (November *Journal,* p.615) fail to discuss a number of important issues relating to the management of women with cervical chlamydia infection in general practice.

Firstly, they state that women diagnosed with cervical chlamydia infection in general practice should be treated and referred to a genitourinary medicine (GUM) clinic for follow-up. It is often argued that all cases of genital chlamydia should be referred to GUM clinics on the grounds that the necessary contact tracing can only be provided in this setting. The only published systematic review of studies looking at partner notification strategies concludes that, as far as chlamydia is concerned, there is conflicting evidence regarding the effectiveness of provider referral (contact tracing partners directly) compared with patient referral (asking the patient to inform his/her partner of the need for diagnosis and treatment).[1] Therefore, we do not know if contact tracing by general practitioners would be less successful than that currently performed by GUM clinics.

Secondly, they argue that many women can be persuaded to attend a GUM clinic if they are given an adequate explanation, and communication between general practitioners and local GUM consultants is good. A literature search revealed no qualitative research exploring the views of patients about sexually transmitted diseases and their management nor any studies describing why patients with a sexually transmitted disease choose to visit a particular clinic or general practice surgery. This question is not merely of academic interest. For example, if one screens for chlamydia in primary care at the same time as a cervical smear, and women who test positive have to attend a GUM clinic for treatment and follow-up, then one needs to know if such women view attending a GUM clinic as acceptable. They might prefer to be treated in primary care.

Thirdly, they suggest that the management of chlamydia by GPs without a research interest in genital chlamydia would be less complete than that offered by GUM clinics. The only published research to address this problem comes from Canada,[2] where researchers found that, despite the availability of recently published national guidelines on the management of STDs, there appeared to be important gaps in the knowledge and practice of many Canadian primary care physicians with regard to genital infections. Therefore, research is needed to determine how GPs manage genital chlamydia, how they view GUM clinics and what their referral policy might be.

In conclusion, we agree with the authors that GPs and practice nurses have an important role to play in reducing the prevalence of cervical chlamydia infection and its serious consequences.

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General practice research

Sir,

Bruce Arroll (February *Journal,* 124) continues the debate on appropriate training for general practice research. He concludes by advocating the supervised MSc and PhDs in preference to an unsupervised MD.

I have developed an interest in research during my 16 years as a GP principal despite a lack of supervision or research training. Therefore, I wish to describe the advantages of the unsupervised approach in contrast to Dr Arroll's letter.

The unsupervised approach encourages development of clinical observation and research *in general practice* rather research *on general practice.* I developed the slightly obscure clinical interest of diving medicine into a subject for case descriptions and treatment protocols which stood up to external peer review in authoritative journals.[1-6] I feel this should encourage GPs to realize that they can still know a great deal about small, defined areas of clinical medicine and make original contributions to knowledge.

I had always wanted to climb the academic mountain and plant my MD flag on the top. Chance intervened but I had to make a change of tack from diving medicine when I was lucky enough to come across a new cause of occupational asthma. I went on a distance-learning occupational medicine course which included epidemiology and statistics. I spoke with a couple of friends in the discipline who warned me about GPs who had been trampled in the rush by academic departments to investigate interesting factories. Therefore, I had to take a calculated risk to maintain control and ownership of the project to proceed into the unknown. My best advice came from my immunologist colleague who is not a clinician. I designed a cross-sectional survey with a nested case control study of the factory in order to test my hypothesis that I was observing a new variation of an old illness.

I attended academic conferences to hear research registrars in respiratory medicine make a meal ticket out of one case of occupational asthma. I kept quiet about my 291 subjects and 24 cases who they would have given their right arms for.

Some might judge my gamble foolish as there was a risk that my study design could have been fundamentally flawed. However, when I finally presented my MD after 5 years, the two examiners of international status, who had written books on the subject, passed it without question.[7]

In conclusion, I feel it would be a shame if the MD degenerated into yet another meal ticket. It should remain a flexible, personal statement for doctors who wish to take as long at they want to conduct their research *in general practice* rather than *on general practice.* If people want supervision for an MD, there are plenty of people to offer advice if they need it. Original ideas for research pro-