Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

The prevention of neural tube defects in post-partum women

Sir,

Periconceptional supplementation with extra folic acid,[1] or a multivitamin preparation containing folic acid[2,3] reduces the recurrence and occurrence rate of neural tube defect (NTD). Also, the Department of Health's expert Advisory group recommends that all women should take an extra 0.4 mg folic acid before conception and during the early months of pregnancy.

Between September 1994 and May 1995 we investigated the awareness of these recommendations and assessed folate intake in 150 women aged 16–41 years (mean 29.1, SD 5.0) on the post-natal ward at the General Infirmary at Leeds. Median folate intake indicated by the dietary questionnaire was 285 μg/day (IQ range 231-339.5 μg/day), with 13 women consuming less than the RDA of 200 μg/day. Smokers had a mean intake of 235.5 μg/day (IQ 210-312 μg/day), which was significantly lower than that of non-smokers whose mean intake was 295.0 μg/day (IQ 243-357 μg/day, P=0.009 Mann-Whitney). When interviewed, 125 (83%) women were aware of the use of folic acid for the prevention of NTD, 15 (10%) were unaware and 10 (7%) had partial or vague knowledge (e.g. 'helped baby', 'helped conception'). Eighty-two per cent of women were able to name foods that are good sources of folate, but only 33% were able to name foods that had folate added to them.

Seventy-four (49% of the total sample) of the 135 who had some knowledge of the importance of folic acid, obtained this knowledge during their present pregnancy. Of the remaining 61, 18 had unplanned pregnancies, leaving 43 who could have taken preconceptional folate. Twenty-nine (19.3% of the total sample) of these women had increased their folate intake before conception, 26 (17.3%) by folate supplements after conception (fair starting between day one and day 28 post-conception, and one started taking folate supplements and three (2%) by increasing their intake of fruit and vegetables. Five mothers had started taking folate supplements after conception (four starting between day one and day 28 post-conception, and one started taking folate supplements when 10 weeks pregnant). Two mothers had increased their dietary intake of folate once pregnancy was confirmed (one by eating more green vegetables and the other by eating fortified cereals). Three had consulted their general practitioners (one at eight weeks), but had not been given folate supplements. Only three women who had complete knowledge and one with partial knowledge of the recommendations and had planned pregnancies had taken no further action.

Table 1. Source of knowledge in 125* women who were aware of the need for folate to prevent NTD.

Source	Number	(%)*
Government leaflet or poster	27	(22)
Newspaper, magazine or TV	36	(29)
GP or other health professional	66	(53)
Other, e.g. friend, relative	21	(17)
Total	150*	

*25 quoted more than one source.

Sources of knowledge for those women aware that folate prevented spina bifida are shown in Table 1.

Thus, we confirmed our earlier finding that less than 20% of women take folate supplements before they conceive and are thus protected from an NTD-affected pregnancy.[4] Two years after the Department of Health recommended that all women planning to become pregnant should consume additional folate, 59% of women were unaware of the recommendations before starting their pregnancy and 10% were still unaware after they gave birth to their baby. Our findings showed the need for a broad-based education campaign targeting health professionals and all women of reproductive age. The need to increase folate intake *before* conception should be stressed.

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Missed opportunities for the prevention of cardiovascular disease

Sir,

In response to a number of enquiries we have received for information on patients' blood pressures, I have enclosed an

Table 1. Mean diastolic and systolic blood pressures (mmHg) for hypertensive men and women, with standard deviations (SD).

	Men				Women			
Age (years)	<45 n=174	45–54 n=320	55–64 n=432	65+ n=308	<45 n=166	45–54 n=308	55–64 n=459	65+ n=506
Mean diastolic blood pressure								
	101.3	102.7	101.9	101.8	102.3	101.6	101.6	101.9
(SD)	(7.2)	(6.6)	(6.1)	(5.9)	(6.4)	(6.7)	(6.5)	(5.9)
Mean systolic blood pressure								
	155.4	163.1	168.1	173.2	159.9	163.4	169.0	176.7
(SD)	(13.2)	(15.0)	(15.2)	(15.6)	(13.8)	(15.9)	(16.7)	(18.1)

addendum to Table 1 of the paper entitled, Missed opportunities for the prevention of cardiovascular disease among British hypertensives in primary care (October *Journal*). This table provides the mean blood pressures (mmHg) by age group and sex, with standard deviations.

If you require further information, please contact Professor Ebrahim at the address below.

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An alternative strategy for cardiovascular risk factor screening

Sir,

There has been considerable debate concerning the relative merits of health screening for coronary heart disease (CHD) in recent years. The two major studies examining this subject came to the conclusion that screening on the scale undertaken in general practice is not worthwhile.[1,2] Part of the problem is associated with Hart's inverse care law in that those who do not attend are more likely to be the 'worried well',[3] and of lesser risk than those that do not.[4]

The LIFE Project, established in 1993 as a result of an alliance between the local authority, the University of Liverpool, and Wirral Health Authority, aims to combat the high CHD mortality rates (SMR=154) in an area of Wirral, called City Lands. This area has a population approaching 29 000 and high unemployment rates (26.5%). The project undertakes numerous intervention campaigns including cardiac rehabilitation for post myocardial infarction and high risk subjects, 'exercise on prescription' in which 64 general practitioners refer patients, special exercise classes for the obese, training of community exercise leaders, a healthy schools project, exercise opportunities for young children ('Krazy Kids'), and health screening for CHD risk factors. In 1995, the project was the national winner in the CHD/stroke category at the Health Alliance Awards for demonstrating good practice.

Results from an opportunistic screening programme, undertaken in venues around the community in a mobile caravan, revealed that only 25% of those screened were male, and furthermore, the prevalence of risk factors did not seem to concur with the high SMR. For example, only 8% of males and 9% of females suffered hypercholesterolaemia (≥ 6.5), and 13% and 5% respectively suffered from systolic hypertension (≥ 160 mmHg). These values are significantly lower than in the Family Hearty Study.[1] We thus adopted an alternative strategy by screening in inner-city public houses so as to identify higher risk individuals. Of 114 subjects screened, 75% were male. Of these, 73% smoked, 48% suffered diastolic hypertension (90 mmHg), and the mean number of units of alcohol consumed per week was 74. If screening is to be implemented purposefully we must advocate the use of more selective methods such as that described, otherwise we may well gain the impression that all is well and fail to recognize those in most need.

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'Within practice' review of referrals significantly alters referral rates — a pilot project

Sir,

Referral rates by general practitioners (GPs) to hospital specialists vary widely, and the reasons behind this variation have been extensively investigated. When referral decisions are reviewed within one suggested analytical framework, a significant difference is found between doctors with high and low referral rates.[1] It may be, therefore, that doctors' individual decision-making processes when considering referral are a major influence on their referral rates. As referral decisions are usually made by doctors in isolation, this could account for the wide variations in referral rates seen between doctors working in the same practice.

Prescribing decisions, like referral decisions, are also usually made in isolation and, again, rates vary widely between doctors. Harris *et al*[2] found that GPs alter their prescribing habits when given information on their own prescriptions and opportunities to discuss their prescribing with other GPs. Our practice, therefore, ran a pilot project to see whether discussion of routine referrals between the partners would have an effect on the practice hospital referral rates. A record was kept of all routine referrals by the doctors to hospital specialists throughout the 24 weeks of the study. During the middle eight weeks of the study the partners held weekly two-hour meetings to discuss the referrals that they had initiated. Each partner presented their own referrals which were then discussed. The aim of the meetings was to provide a supportive environment to discuss the referrals in an open ended way and learn from each others'

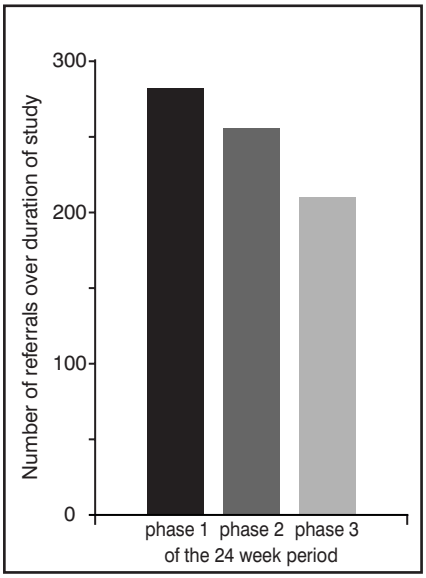

Figure 1. Number of referrals made by doctors in the 24 week duration of the study.

skills and experience. (A graph of the total referral numbers is shown in Figure 1.) The total number of referrals dropped by 25% over the course of the study. This reduction was still apparent when the referral rate was calculated both by list size and by the number of consultations during the study period.

Our pilot project showed that, in our practice, discussion between the doctors about our hospital referrals led to a reduction in total practice referral rates that was maintained for at least eight weeks after the meetings finished. A randomized controlled trial, funded by the National Health Service (NHS) Research and Development Directorate, is currently underway to see whether this effect is confirmed in a larger study and, if so, whether this is due to an alteration in the factors influencing the doctors when they decide to refer.

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The pilot project was funded by the Allen and Hanbury Foundation.

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Deaths caused by asthma

Sir,

An additional factor that may contribute to deaths caused by asthma is running out of inhaled medication. Do Mohan *et al*[1] have any data on this? Asthmatics often attend accident and emergency departments and general practices for replacement inhalers when their current ones are empty.

Over a six month period, I recorded all consultations where an asthmatic presented with or was found to have an empty inhaler. I was working as a locum in general practice for nine sessions a week. There was a total of 11 asthmatics, five female and six male, with a median age of 19 years (range 5yrs–79yrs). Eight had an accurate exacerbation of asthma with a duration that ranged from two to seven days. Three were subsequently prescribed oral steroids in addition to replacement inhalers. When asked how long ago they had run out of inhaled medication, replies ranged from three hours to 54 hours (median 48 hrs). The 79 year old and the parents of the five year old using a spacer device were not aware their inhaler was empty and also required oral steroids. None of the asthmatics required admission or had been admitted in the past, and the duration of their asthma varied from 6 months to 30 years (median 8.5 yrs).

One third of asthmatics have difficulty assessing the fullness of a metered dose inhaler, and when given a metered dose inhaler that was less than 10% full, 15 out of 98 asthmatics overestimated how full it was by more than a quarter.[2] I suggest that all asthmatics should be asked if they know when their type of inhaler is empty and should be encouraged to keep a spare, full reliever and and preventer inhaler.

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Views of Asians and non-Asians on over-the-counter medication

Sir,

Rashid *et al* (October *Journal*) showed that Asians in Leicester, presumably mostly Indian Hindus and Sikhs, are less in favour of medicines being made available over the counter (OTC) than white British people in Leicester. They conclude that these 'Asians' would be less willing to self-medicate or seek the advice of a pharmacist, rather than going to the general practitioner.

It is dangerous to generalize behaviour for 'Asians' since they are such a diverse subgroup varying in language, religion, custom, diet and health beliefs. From studies on Pakistani Moslem diabetic patients residing in Nottingham and Manchester,[1] it is clear that 27% of the Nottingham patients and 68% of the Manchester patients were using traditional remedies and foods in addition to medication received through their GPs. Very few actually consulted a hakim (traditional practitioner), most obtaining their supplies from local traditional shops. There is, therefore, a culture of OTC purchasing in these subgroups. They may well have difficulty consulting a white pharmacist, but no difficulty in the idea of self-medication.

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Consultant obstetricians' opinions of GP obstetrics

Sir,

The recent survey regarding consultant obstetricians' thoughts about general practitioner (GP) obstetrics drew rather one-sided conclusions (October *Journal*[1]). These Northern Region consultants felt that women don't want more primary care involvement, despite convincing evidence to the contrary.[2] The consultants perceived a 'lack of demand' from the women. This may simply reflect the fact that women are not frequently asked what they would pre-

fer. When they are, 90% wish to be give a choice and roughly 20% would choose a home delivery.

The 35% of consultants who believed low-risk home delivery to be unsafe may be reassured by a plethora of recent research, albeit observational, that adds to a previously reassuring evidence base.[2,3,4] One Dutch study suggests home delivery is actually safer when measured as 'maximal result with minimal intervention'.[5]

Finally, any lack of enthusiasm amongst GPs is hardly surprising at a time when core services must be defined due to a burgeoning demand for new primary care responsibilities.

The question is not whether home deliveries are possible or safe, but how we reorganize our services in the United Kingdom to allow women to make informed decisions that can be acted upon. We would do well to learn from Holland where midwives take primary responsibility and rigorously assign women to risk categories. Primary care teams provide, at the least, continuity of care and standard emergency cover. GPs wishing to provide higher levels of care need special training and adequate remuneration. Consultants should not be expected to plan changes alone; they will need to work together with midwives and GPs. All three groups will need to embrace change and establish new systems.

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Nappy pads for collecting urine samples from infants — pilot study

Sir,

Detection of urinary tract infection (UTI) in infants is important in the prevention of renal damage and its long term sequalae.[1,2,3,4,5] Although general practitioners (GPs) are exhorted to be vigilant in diagnosis in infants,[6] collecting urine samples is difficult in those who are still in nappies.

In 1991, Ahmed *et al*[7] reported the successful use of urine squeezed from nappies for the diagnosis of UTI. Subsequently, nappies became unsuitable for this method because the manufacturers added absorbent gel granules. To overcome this, Vernon reported the use of an absorbent pad placed within the nappy.[8] Fibres from the pad are placed in the barrel of a syringe and the urine squeezed out into a standard urine collection bottle. Previous work using pads was carried out in a hospital setting, thus the Cumbria Practice Research Group carried out a pilot study to evaluate their use in a community setting.

We identified 17 children under the age of two years presenting with any illness where examination of the urine was thought to be necessary. Two general practices participated in the study, which took place over a 12 month period.

The method was assessed for acceptability and practicality by completion of questionnaires by parents, nurses, GPs and laboratory staff. Twenty five questionnaires were returned. Of the 16 returned (16/17) from parents, 14 reported no difficulties with the method. One was anxious about the baby soiling the nappy and the other had difficulty returning the pad to the surgery on the same day. One parent commented that the method was easier than the adhesive bag method. One health visitor, three practice nurses, three GPs and two laboratory staff reported no difficulties with the method.

The method therefore proved acceptable to community staff and parents alike, but the study was not designed to address the issue of whether the method is able to accurately detect UTI in infants in the community. Sources of inaccuracy may include delay in the parent removing the pad from the nappy, delay in returning it to the surgery, or laboratory delay in extracting the urine from the pad. These variables are difficult to control in a community study but need to be addressed. We plan a further study.

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Recruitment of general practitioners and patients in a sore throat study

Sir,

The success of studies in primary care depends on the willingness of general practitioners (GPs) to participate. We investigated whether personal or practice characteristics are correlated with a willingness to particpate and with the number of enrolled patients. This investigation was carried out as part of an extended clinical study on patients (aged 4 to 60 years) presenting with sore throat.[1,2] To recruit GPs, a departmental newsletter announcing the study was sent to a network of 450 GPs at that time active in education and research. One hundred and seven doctors asked for information, of these, 71 decided to participate. A NLG 50.00 remuneration (11/2 times the cost of an encounter) was given for each included patient; that is for a complete registration form including throat swabs and blood samples. The 107 interested GPs were

sent a questionnaire that assessed their personal and practice characteristics. The 90% response rate to the questionnaire was quite high and suggests that the data gave a reliable impression of the GPs invited to the study:

- Participating GPs tended to be those who followed vocational training, were younger, or had fewer patients; confounding nor effect modification were found. More than half of the participitating GPs indicated that their decisive motivation to participate was related to the relevance of the study. Social reasons were also listed; for example, being well acquainted with the researchers or having a colleague in a practice deciding to participate. Those who refused to participate most frequently referred to the elaborate study procedures or to practical reasons.
- On average, the GPs enrolled approximately one patient each month ($\bar{x}$:0.75; ranging from 0.0 to 3.7 patients each month). Being female and a high delegation of medical tasks to the practice assistant were independent determinants of the number of enrolled patients. Seventeen GPs (24%) did not enroll any patient. Four of the eight GPs who participated because they knew the researchers, and had colleagues at the university department, did not recruit any patients compared with nine of the remaining 58 GPs.

The most frequently mentioned decisive reason to participate was the relevance of the study, which is in accordance with other studies.[3,4] Of those refusing to participate, one-third reported practical problems. Financial reasons were never mentioned, which is in line with the findings of Silagy and Carson (1989).[3] A high degree of delegation of medical tasks to the practice assistant (an in-between of a practice nurse and a secretary who is qualified to carry out minor medical procedures, such as measuring blood pressure, taking swabs and venous blood sampling) was a determinant of the number of patients enrolled. This might mean that the efficiency of the participating doctors is an important factor. The fact that the degree of delegation did not correlate with the willingness to participate may indicate that GPs were not conscious of the importance of this factor in the enrollment of patients. The result showing female physicians as having enrolled more patients is interesting but difficult to interpret and must be handled cautiously because of the small study size.

Persuading familiar colleagues to participate in a study is risky. In general, however, personal contact between the research team and the participating GPs and their practice staff members seems a good investment.[5,6] We prefer such contacts because of the reliability checks as well as the incentive. Other incentives might include a newsletter with information about the number of patients enrolled, the progress of the study, relevant abstracts from international literature, and possible prizes for the most successful recruiting practices. In this study, the enrolled patients did not differ from those not enrolled with regard to sex, age, insurance mode, or clinical features (57% included: 43% excluded).[1] The difference between enrolled and eligible patients may impair external validity. This corroborates the necessity of a good registration of personal and clinical features of eligible as well as enrolled patients, which should be published with a specification of external validity.

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Occupational medicine and training for general practice

Sir,

I read with interest the paper by Dr Parker (November *Journal*) and was glad to see that our college is encouraging research into how much occupational medicine is incorporated into the training of general practitioners. After all, if we are trying to practice holistically, a patient's occupation will have a major influence on his state of health.

I would, however, like to make one observation with regard to Dr Parker's paper. He decided to target course organizers for his research into how much instruction of occupational health matters is taught to our registrars, but he should know better than most that the majority of the teaching is given to registrars by their GP trainers. A sample of GP trainers would, therefore, have been more appropriate.

In our area, the University of Bristol produces a curriculum guide for GP registrars, which includes occupational health matters, thus it is certainly covered in my training of registrars. Could we therefore take this important research question further?

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Mental health social work in primary care

Sir,

The difficulty of providing a 'personal service' to mentally ill patients by increasingly hard-pressed general practitioners (GPs) is well depicted by Graham Curtis Jenkins (November *Journal*). Like Anthony Hazzard,[2] his remedy is to supply such patients with counsellors. This presumes that counsellors have expertise in adult mental health (they often do not), and can address those environmental factors that so often underpin the 'chronicity' of such patients. Webber[3] recognized that this is beyond most counsellors' training or capabilities.

Certainly, time spent listening to patients with psychosocial problems can be invaluable, *if* the listener knows what to do with what is being heard. A thorough assessment may be all that is needed for some patients to find their own solutions. Others will benefit from the support and shared focus on problems available through counselling. However, more comprehensive interventions that address

physical, interpersonal, psychological and material needs require a wider perspective and more specialist skills and practical know-how.

In recognition of mental health patients who have decreasing access to secondary care services, but whose problems are enduring, two pilot schemes have been established within local primary care sites where psychiatric social workers (PSWs) work collaboratively with GPs. Interim data from one scheme indicates, in line with our pre-pilot sutdy,[4] that PSWs are beginning to treat patients characterized by more severe and refractory forms of depression or anxiety, poor physical health, deleterious close relationships, self-harm, major debts, child-care and housing problems, and other situational stress. This is not an average counsellor's caseload.

The advantages of being in-house include direct communication between PSWs and GPs, openness about our separate professional processes, and improved liaison with psychiatric services. The PSWs' working model involves a full needs-assessment followed by focused, time-limited interventions that combine therapeutic work and practice help. The PSWs also derive satisfaction from working with clients for whom positive change rather than simple maintenance is possible.

Both schemes use standardized measures of need, morbidity and user satisfaction, and are evaluated independently. Many opportunities for service development and joint-training are emerging. The GPs involved have wholeheartedly welcomed the first scheme, not least for shared burden of care. Perhaps the recent White Paper, *Choice and Opportunity*, will lead to more of such schemes, whereby the most appropriate practitioners are placed closest to those clients whose psychological *and* social predicaments can be improved?

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