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; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Women's attitudes to the development of midwifery group practices

Sir,

Fenwick *et al* report GPs' attidudes to midwifery group practices (July *Journal*).[1] In this letter, we wish to report the views of women on midwifery group practices.

In our district, one of the local acute NHS trusts decided to change the configuration of midwifery services with the aim of improving continuity of maternity care. Thus, our locality commissioning group (and putative primary care group) decided to carry out a survey of the views of women on the proposed change to group midwifery practice from our current community-based midwifery teams. A questionnaire was developed and piloted. All 16 practices within the locality were included, although only 10 practices returned the questionnaire. Questionnaires were administered to women attending a GP antenatal clinic who had previously had a baby, as we felt that they were more likely to be able to comment on the proposed changes based on their previous experience. Seventy questionnaires were received and Table 1 shows the key results.

Clearly, caution needs to be exercised in interpreting this questionnaire, which involves small numbers, but we believe that there are valuable lessons to be learnt from this exercise, which will be of interest to other primary care groups. It is noticeable that the most common response to statements 1, 2, 3, and 4 was 'don't mind', which would suggest a degree of ambivalence among women in our survey about continuity of carer. By contrast, there was a definite preference for their postnatal care to be provided by one of their antenatal midwives.

In parallel, we conducted a SWOT analysis of maternity services from GPs' points of view. For the GPs, a major issue was the proposed size of the midwifery group practice. There was concern about a change from the current community-based teams where relationships and communication had been excellent. GPs valued the continuity of services from known midwives. Further concerns included lack of any written evidence-based protocols for antenatal care, the detachment of midwives from primary health care teams, and, most importantly, the level of consultation before establishing new schemes: a finding similar to that of Fenwick *et al*.

We also looked at the research evidence for continuity of carer. A review of the evidence in the Cochrane database showed that women who had continuity of care by a team of midwives were less likely to have intrapartum analgesia and babies requiring resuscitation, and were more likely to be satisfied.[2]

The current debates illustrate the difficulties of implementing national policies, such as those in *Changing Childbirth*,[3] which require a major restructuring of services. We would wish to share with others how we tackled this issue using an approach that uses evidence, assesses users' views, and assesses health care professionals' views. In this way, our intention is to promote an effective, systematic, and evidence-based policy-making system — a forum for discussing maternity services has now been set up between acute NHS trusts and our primary care group.

MAYUR K LAKHANI

Department of General Practice
and Primary Health Care
Leicester General Hospital
Leicester LE5 4PW

RON HSU

Leicester Health Authority
Leicester

Table 1. Views of 70 women on proposed change to group midwifery practices. Number (%).

Statement	Strongly agree	Agree	Don't mind	Disagree	Strongly disagree	Blank
1. I would like my baby to be delivered by a midwife whom I have met before during my antenatal care.	12 (17)	23 (33)	33 (47)	1 (1)	0	1 (1)
2. I would rather see a few midwives (1-3) during my antenatal care, although this could mean that the midwife who delivers my baby in hospital will not be known to me.	0	10 (14)	35 (50)	23 (33)	1 (1)	1 (1)
3. I would be willing to see more midwives (4-6) if there is a chance that the midwife who delivers my baby will be known to me.	3 (4)	25 (36)	28 (40)	9 (13)	4 (6)	1 (1)
4. It is important to me to see the same midwife each time I have an antenatal check.	3 (4)	20 (29)	41 (59)	3 (4)	1 (1)	2 (3)
5. When I come home it is important to me to see one of the midwives who did my antenatal checks.	14 (20)	33 (47)	23 (33)	0	0	0

IAN SCHOFIELD

South Charnwood Primary Care Group

References

1. Fenwick N, Morgan M, McKenzie C, Woolf C. General practitioners' attitudes to the development of midwifery group practices. *Br J Gen Pract* 1998; **48:** 1395-1398.
2. Hodnett ED. Continuity of caregivers during pregnancy and childbirth. [Cochrane review.] In: *The Cochrane Library.* (Issue 3.) Oxford: Update Software, 1998.
3. Department of Health. *Changing Childbirth*. Report of the expert maternity group. London: HMSO, 1993.

The RCGPs' questionnaire for measuring SHOs' satisfaction with hospital training

Sir,

We are pleased to see the evaluation by Hand *et al* of the RCGP questionnaire on senior house officer (SHO) training (July *Journal*),[1] and have watched its evolution with interest. Although the study looked only at Anglia, the questionnaire, or its precursor, has been seen in use nationally at other Royal College visits.

Reports emphasize the importance of regular feedback from the SHOs about their trianing,[2,3] and Hand questions the feasibility of doing this with previous questionnaires. However, we have obtained regular six-monthly feedback using the local 'SHO Educational Audit Project' (SEAP) questionnaire since 1994 on all posts in South East Scotland.[4] By obtaining a series of questionnaires from different SHOs about each post, a picture of each post has emerged that is independent of the enthusiasm of the SHO. It has enabled us to identify problem posts, bring in help to improve these posts, give anonymous feedback on each post as an incentive for improvement, and provide follow-up to ensure that the post has improved. We have noticed the Portsmouth formative assessment rate (appraisals) rise from 25%, similar to that reported by Hand, to over 63% over the period 1994 to 1996.[5]

The SEAP questionnaire has been validated against interview data and educationalist opinion, but the reliability coefficients are similar to those obtained by Hand. These reliability coeffecients are the lower end of desirable and, for the RCGP questionnaire, are very low in two areas.[1] Hand also reports that the response rate of the RCGP questionnaire was 58.8% overall, and stated it was similar to other studies.[1] At Portsmouth, our response rate to the SEAP questionnaire has been consistently above 95% since 1994. We use a covering letter, provide a stamped addressed envelope, give reminders at meetings, and follow-up all non-responders by letter or telephone. To administer a national questionnaire would require time spent in building up enthusiastic local units to ensure an equally good response rate.

We support the concept of a national questionnaire and feel that the RCGP questionnaire could be the basis for this after revisiting the reliability data and question format. What is also required is a system of organization and administration in order to apply one questionnaire nationally, six-monthly to all specialties and on behalf of all colleges, using enthusiastic local units and well-funded data handling facilities.

MARK RICKENBACH

Park Surgery
Hursley Road
Eastleigh
Hants SO53 2ZH

JOAN DUNLEAVEY

Wessex Research Network Coordinator

PAUL LITTLE

Aldermoor Health Centre
Aldermoor Close
Southampton SO16 5ST

MARK MULLEE

University of Southampton
Tremona Road
Southampton SO16 6YD

WILLIAM PATTERSON

Lister Postgraduate Institute
11 Hill Square
Edinburgh EH8 9DR

References

1. Hand CH, Adams M. The development and reliability of the Royal College of General Practitioners' questionnaire for measuring senior house officers' satisfaction with their hospital training. *Br J Gen Pract* 1998; **48:** 1399-1403.
2. Academy of Royal Colleges. *Recommendations for training of senior house officers*. London: Academy of Royal Colleges, 1996.
3. COPMED, UK Conference of Deans. *SHO training: tackling the issues, raising the standards.* London: COPMED, 1995.
4. Rickenbach MA. Hospital vocational training. *BMJ* 1994; **309:** 196.
5. Rickenbach MA, Dunleavey J, Little P, Mullee M. Senior house officer training. Impact of existing peer review visits needs to be increased. *BMJ* 1997; **314:** 1829-1830.

Developing, validating and consolidating the doctor–patient relationship

Sir,

Gore and Ogden's paper (July *Journal*)[1] concerns an important area that has seen little research. It is also an example of the increasing recognition of the value of qualitative approaches in general practice research.[2] Unfortunately, this paper appears to suffer from a number of serious shortcomings that have important implications for the credibility of its findings and, more generally, for the credibility and usefulness of qualitative research reported in medical journals. We identify three issues that require further debate.

First, any paper, qualitative or not, should identify its context in terms of existing literature: this enables an assessment of the originality of the work and allows the authors to explain how their work contributes to theory-building and development. Gore and Ogden's claim that 'no research has examined the patients' views of the doctor–patient relationship' suggests that their literature review was less than exhaustive: Tuckett *et al*'s classic text[3] is just one of the examples of work in this area that they could have discussed in more detail.

Secondly, the overall quality of the study can be questioned. While no consensus has yet emerged on how to assess quality of qualitative research, criterion-based 'checklists' exist that can inform the process of evaluation (for example, such as that developed by Boulton *et al*[4]). We suggest that the Ogden and Gore study is significantly flawed in relation to the sample chosen, methods of data collection and analysis, and quality of reporting and presentation. It is unclear why, if the aim is to examine patients' views of the process of establishing a relationship with their GP, only frequent attenders were interviewed. The method of sampling, and justification for its use, is not discussed in detail. Similarly, the process of data collection and analysis are inadequately described. We are given no conceptual framework for the data analysis, only a reference to a standard text on 'how to do it'.[5] This textbook offers a range of data analysis techniques; the authors do not specify which one they chose. This is equivalent to a quantitative paper failing to report which

statistical tests were preformed.

Thirdly, the fact that the interviewer was a GP is problematic: qualitative interviewers should seek to discover their informants' perspectives and interpretations. GPs may be so 'embedded' in the culture of general practice that they find it difficult to explore the underlying assumptions, or may find it hard to resist translating what the patient says into the medical model. Given the increasing numbers of GPs 'doing' qualitative research, this area needs more attention than it has hitherto received.[6] One approach, absent from this paper, might be to start the discussion section with the interviewer reflecting on the effect they thought being a doctor had on the interview process.

To conclude, we would like to see medical journals assess qualitative research papers with the same rigour with which they assess quantitative papers, and also to publish such papers in a format that allows the methodology to be properly assessed.

TIM STOKES

Department of General Practice
and Primary Health Care
University of Leicester
Leicester General Hospital
Gwendolen Road
Leicester LE5 4PW

MARY DIXON-WOODS

Department of Epidemiology and Public Health
University of Leicester
22-28 Princess Road West
Leicester LE1 6TP

References

1. Gore J, Ogden J. Developing, validating, and consolidating the doctor-patient relationship: the patients' views of a dynamic process. *Br J Gen Pract* 1998; **48:** 1391-1394.
2. Britten N, Fisher B. Qualitative research and general practice. [Editorial.] *Br J Gen Pract* 1993; **43:** 270-271.
3. Tuckett D, Boulton M, Olsen C, Williams A. *Meetings between experts.* London: Tavistock, 1985.
4. Boulton M, Fitzpatrick R, Swinburn C. Qualitative research in health care: II. A structured review and evaluation of studies. *Journal of Evaluation in Clinical Practice* 1996; **2:** 171-179.
5. Miles MB, Huberman AM. *Qualitative data analysis: a source book of new methods.* Newbury Park, CA: Sage, 1993.
6. Hoddinott P, Pill R. Qualitative research interviewing by general practitioners. A personal view of the opportunities and pitfalls. *Fam Pract* 1997; **14:** 307-312.

Acupuncture in smoking cessation

Sir,

Waite and Clough's trial of acupuncture in smoking cessation (August *Journal*)[1] has more robust methodology than many other studies on this subject,[2] but unfortunately their principal conclusion is not supported by the data they present. They state that simple ear electroacupuncture treatment is 'significantly more effective than placebo treatment'. They base this assertion on a two-tailed *P*-value of 0.055 for the difference between proportions of smokers who quit in the control and intervention groups. This value, however, is not significant at the traditional 5% probability level, and indicates that the observed effect of acupuncture has more than a 1-in-20 possibility of having arisen by chance. This is not surprising as the sample size calculation implies that the study is only large enough to confidently detect a difference of 25% between control and intervention groups.

Waite and Clough also state that 'subject randomization to the two treatment groups ensured that selection bias was avoided'. Their small trial sought a large treatment effect though, and, in this situation, important differences can arise between treatment and intervention groups by chance.[3] Waite and Clough suggest that their trial proves acupuncture is effective. They argue that previous trials failed to demonstrate this because the site of 'placebo acupuncture' used was capable of promoting smoking cessation, thus mitigating against detecting the effect of 'real acupuncture'. An alternative explanation is that having no quitters in a control group comprising motivated volunteers is an unusual, chance result. This would be consistent with the findings of a recent systematic review of trials of acupuncture in smoking cessation.[2]

In 1979, the first trial of general practitioners' anti-smoking advice also had a control group with an unusually low level of smoking cessation.[4] Accordingly, this study estimated that 5% of smokers would quit within one year of being advised to do so by their general practitioner. This inflated estimate of the efficacy of general practitioner's advice remains widely-quoted, depsite systematic review evidence that is incorrect.[5] This demonstrates the value of assessing the efficacy of anti-smoking interventions over a number of homogenous studies.

The authors are wrong to call for acupuncture treatment to be made available as a consequence of their trial. A more reasoned response to their data would be to call for larger trials comparing the efficacy of real acupuncture with their type of placebo acupuncture.

TIM COLEMAN

Faculty of Medicine
University of Leicester
Leicester General Hospital
Gwendolen Road
Leicester LE5 4PW

References

1. Waite NR, Clough JB. A single-blind, placebo-controlled trial of a simple acupuncture treament in the cessation of smoking. *Br J Gen Pract* 1998; **48:** 1487-1490.
2. White AR, Rampes H. Acupuncture for smoking cessation (Cochrane review). In: *The Cochrane Library.* (Issue 3.) Oxford: Update Software, 1998.
3. Treasure T, NacRae KD. Minimization: the platinum standard for trials. *BMJ* 1998; **317:** 362-363.
4. Russell MAH, Wilson C, Taylor C, Baker CB. Effect of general practitioners' advice against smoking. *BMJ* 1979; **2:** 231-235.
5. Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle chance in general practice. *Fam Pract* 1997; **14:** 160-176.

Urine collection pads

Sir,

It was with wry humour that I read Tim Alexander's (August *Journal*)[1] response to our letter (June *Journal*) on urine sample collection.[2] I have also felt frustrated by the amount of effort taken to affect any change; setting up the provision of urine collection pads has been beset by difficulties. However, these pads are now easily and cheaply available direct from the suppliers, Ontex Ltd (who recently took over both the manufacturing and marketing). Their telephone number is 01536 269744. This has already improved the availability of urine collection pads to GPs. Perhaps primary care groups might consider buying a case of pads and sharing them?

SUE VERNON

Paediatric Nephrology Unit
Sir James Spence Institute of Child Health
The Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne NE1 4LP
Email: S.J.Vernon@ncl.ac.uk

References

1. Alexander T. Urine sample collection. *Br J Gen Pract* 1998; **48:** 1527.
2. Vernon S, Foo CK, Plant ND. Urine sample collection. *Br J Gen Pract* 1998; **48:** 1342.

Impact of guidelines for the diagnosis of UTI

Sir,

Reagant strips for rapid near patient assessment for urinary tract infection (UTI) are now widely available at low cost. They have been evaluated in a variety of populations relevant to general practice.[1-4] In high prevalence populations they have a sensitivity similar to microscopy for the diagnosis of UTI, which allows empirical therapy to be started with confidence. In low prevalence populations the specificty is excellent, with negative tests allowing the exploration of alternative diagnoses, avoidance of inappropriate antibiotic therapy, and the reduction in the use of the laboratory for culture.[5]

We decided to audit the implementation of guidelines for the use of rapid reagant strips, drawn up jointly by GPs and microbiologists in a local general practice serving a population of 4000 (Box 1). An EMIS template was created on the practice computer, which contained the appropriate Read codes, to allow the results of rapid reagant urine tests (Multistix, Bayer) and any urine culture to be recorded prospectively. Training was given to all users in the performance and reading of the strips by the manufacturer.

Perceived advantages of the guidelines to their users were:

- A clear indication (with a high degree of confidence) of the likelihood that urinary symptoms represented true UTI. This facilitated immediate initiation of treatment or 'marking down' the likelihood of UTI in the differential diagnosis.
- More rational use of empirical antibiotics.
- Fewer review appointments and telephone calls to discuss negative culture results.

The strips were particularly useful for decision making at times when sending urine for culture is impractical; e.g. Friday afternoon surgeries, weekends, and evening visits. The use of the test strip was enthusiastically received by all members of the primary care health team, including the community and pratice nurses.

In the seven months prior to the implementation of the guidelines, the mean number of urine samples sent to the laboratory from this practice was 33 per month (range 23–40) compared with a mean of 15 per month (range 9–20) in the following seven months; a fall of 53% in laboratory usage. The mean monthly sampling freqency from five other practices of similar size over the same time periods were 37 and 32 urines tests per practice respectively.

Urine culture is the most common microbiological test requested by GPs, and, in our laboratory, 63% are culture negative. The cost of culture is 10-fold higher than the cost of the reagent strip. The widespread implementation of guidelines for the use of reagent strips could improve patient management and reduce costs to the National Health Service.

I C J W BOWLER
B L ATKINS
B I F BATCHELOR

Oxford Public Health Laboratory
Level 7
The John Radcliffe
Oxford OX3 9DU

J ANDERSON

The Health Centre
Fane Drive
Berinsfield
Wallingford
Oxon OX10 7NE

P GALLOWAY

Marston Health Centre
24 Cherwell Drive
Oxford OX3 0LY

- For patients with symptoms of UTI:
  - Reagent strip positive[a] → treat. MSU not normally required but see points 3 and 4 below.
  - Reagent strip equivocal[b] → consider treatment and send for culture.
  - Reagent strip negative[c] → observe.
- For patients with atypical symptoms when exclusion of UTI is required:
  - Reagent strip positive or equivocal → send for culture.
  - Reagent strip negative → excludes UTI.
- Urine should always be sent for culture from the following groups:
  a) Routine antenatal
  b) Failure of a UTI to respond to treatment or relapse of recurrent UTIs
  c) Children and men if reagent strips are positive or equivocal
- For catheterized patients, if the patient becomes unwell and there is no other obvious cause test urine with reagent strip:
  - If negative → excludes UTI
  - If positive or equivocal ®send urine for culture

[a]Leucocyte esterase and nitrite tests both positive; [b]either leucocyte esterase or nitrite tests positive; [c]both leucocyte esterase and nitrite tests negative.

Box 1. Guidelines for urine testing.

References

1. Hiscoke C, Yoxhall H, Greig D, Lightfoot NF. CValidation of a method for the rapid diagnosis of urinary tract infection suitable for use in general practice. *Br J Gen Pract* 1990; **40:** 403-405.
2. Woodward MN, Griffiths DM. Use of dipsticks for routine analysis of urine from children with acute abdominal pain. *BMJ* 1993; **306:** 1512-1513.
3. Lejeune B, Baron R, Guillois B, Mayeux D. Evaluation of a screening test for detecting urinary tract infection in newborns and infants. *J Clin Pathol* 1991; **44:** 1029-1030.
4. Flanagan PG, Rooney PG, Davies EA, Stout RW. Evaluation of four screening tests for bacteriurnia in elderly people. *Lancet* 1989; **i:** 1117-1119.
5. Lachs MS, Nachamkin I, Edelstein PH, *et al.* Spectrum bias in the evaluation of diagnostic tests: lessons from the rapid dipstick test for urinary tract infection. *Ann Intern Med* 1992; **117:** 135-140

Osteoporosis in patients attending a fracture clinic

Sir,

The early identification and treatment of osteoporosis and ostopenia might prevent the development of serious life-threatening fractures. This exploratory study aimed to describe the bone density of patients attending our local fracture clinic, held each weekday and Saturday mornings.

Between 1 January 1996 and 18 April 1996 we attended 28/73 fracture clinics. All 194 patients seen in the clinics were interviewed and those ⩾20 years of age were offered bone densitometry. Seventy-three of the 194 were too young, three had difficulties with transportation (all >93 years of age), one had left the area, one was already on treatment, 36 refused to take part, and 19/194 patients were not contactable. In total, 61/116 (52.6%) attended for densitometry.

The mean (SD) age of male responders was 40.7 (13.8) years (n = 27), and for female responders was 52.6 (16.1) years (n = 34). The mean (SD) Z scores (number of standard deviations from age, sex-matched population reference values) for the study population as a whole, and for males and females, is shown in Table 1. Men who attended the fracture clinic appeared to have lower Z scores, in com-

Table 1. Z scores for patients attending a fracture clinic.

	L2–L4 mean (SD)	L2–L4 95% CI	Femoral neck mean (SD)	Femoral neck 95% CI
All patients (*n* = 61)	-0.477 (1.14)	-0.76 to -0.19	-0.413 (1.0)	-0.66 to -0.16
Males (*n* = 27)	-0.715 (1.22)	-1.2 to -0.23	-0.658 (1.11)	-1.14 to -0.17
Females (*n* = 34)	-0.289 (1.05)	-0.66 to 0.08	-0.291 (0.88)	-0.53 to 0.09

parison with age-matched population reference values, than women. When T scores (number of standard deviations from young, adult sex-matched population reference values) for L2–L4 and the femoral neck were considered together, 15/27 (57.5%) of the men and 25/34 (73.5%) of the women, were osteopenic or osteoporotic according to WHO guidelines. Twenty-four of the 59 (41%) patients reported a previous fracture and 35/59 (59%) reported no previous fracture. The mean (SD) Z scores at L2–L4 of those patients who reported a previous fracture was significantly lower, at –1.491 (1.43), than those who did not: –0.628 (1.28); 95% confidence interval difference between means ranging from 1.6–0.13. Similarly, the mean (SD) Z scores at the femoral neck of those patients who reported a previous fracture was significantly lower, at –1.42 (1.22) than those who did not: –0.757 (1.23); 95% confidence interval difference between means ranging from 1.31–0.01.

We distinguished fractures that occurred in a sporting setting from those that occurred in a non-sporting setting. There was no difference in the Z scores between these two groups at either L2–L4 or the femoral neck.

A recent local authority audit by general practitioners in our region suggested that few patients who have sustained fractures are referred for bone densitometry. This study suggests that a substantial proportion of fracture clinic patients may be osteoporotic or osteopenic, particularly if they have had previous fractures, and screening of such patients may provide an ideal opportunity for the identification of those who would value from early treatment.

D N LEITCH
P S KHURANA
J N FORDHAM

Department of Rheumatology
South Cleveland Hospital
Marton Road
Middlesborough TS4 3BW

Correction

We would like to apologize for omitting to print the name of the author of the letter entitled, Near patient testing for anticoagulation (September *Journal*, pp1615-1616). This was written by Dr B A Edwards, of Brookland House, 501 Crewe Road, Wistaston, Crewe, Cheshire.