Letters

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E-mail consultations in general practice

E-mail is an established method of communication in business, leisure, and education, but not yet in health care. The medical profession exhibit a polarity of views on e-mail, ranging from enthusiasm at a medium based around users' convenience, to hostility based upon concerns about security and intrusion into clinicians' work patterns. We used a qualitative analysis of interactions and an electronic user survey to evaluate a practice e-mail service for repeat prescription orders, appointment booking and clinical enquiries.

Among the 150 patients, aged 24–85 years, who participated, satisfaction with the service was very high. Patients specifically commended the practice for setting up a facility to allow communication outside standard working hours and for the ease of ordering repeat prescriptions. Patients were pleased to have a means of seeking their doctor's comment or opinion without bothering him or her by making and attending a formal face-to-face consultation. E-mail dialogue was polite, factual, but less formal than standard letters.

Use of an e-mail consultation facility worked well within an urban practice, was deemed helpful by patients, and had no apparent increase in GP workload. Our results suggest that there may be an unmet need among patients for clinical e-mail services, and that such services may have positive outcomes for patients and practices.

A detailed description of methods is shown on: http://www.show.scot.nhs.uk/gpsites/t/11132/home.htm.

We should welcome comment and discussion.

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Differences in health care in South Africa and the UK

We read Dr Kruger's comment on the difference between health care in South Africa and the UK and the stinging rebuke that, should he become ill, he would fly back to South Africa for his health care, with some concern.[1]

His reflections are based on the power of the market and the perils of 'socialist' medicine. We suspect, however, that he writes from the perspective of the economically advantaged healthcare consumer in South Africa. Such a consumer can benefit from the power of the market, which has made high technology and interventionist medicine more readily available in South Africa than to similar people in the UK. But let us compare the case for the economically less advantaged healthcare user in both countries.

In the UK, whether in urban deprived areas of the inner cities or in the economically disadvantaged parts of the rural hinterland, everyone has access to interventionist high-tech medicine. Perhaps access is not quite so timely or the care provided in quite so pleasant an environment as Dr Kruger can access in South Africa? But can he say that everyone in Soweto or Transkei has access to health care, which the economically advantaged in South Africa enjoy, when 85% of people in South Africa have no health insurance?

We acknowledge that health care in the UK chafes under a huge burden of bureaucracy and that frontline healthcare staff often feel they are outnumbered by the 'Elevator People'; there are delays in access and the care environment can often be improved. However, we must not lose sight of the simple truth. The UK's much derided socialist and imperfect NHS has succeeded in delivering first-world care to all its people, whether they have the economic clout to access the healthcare market or not.

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References

1. Kruger A. Decisions and elevators. *Br J Gen Pract* 2004; **54:** 398.

Author's response

I can hardly agree more with a viewpoint than with this of my esteemed colleagues. Our only possible difference is the best way to achieve the same end.

Their 'suspicions' about my economic position and what I 'can access', however, appear prejudiced and stereotyped. Actually one of 'the 85% without health insurance' myself, I have empathy with those in the same situation. Offering my services, and often medicines, for free where the need was obvious, taught me how much more the same resources can achieve in the absence of 'management' by bureaucracy.

But also, I noted how much better medical intervention worked when the patient took 'ownership' thereof by paying, even if with a chicken or a few vegetables from their country garden ...

It likely makes political sense taking credit for supplying services to 'all', and economic sense using other people's money (tax) to fund it. If the objective is purely philanthropic, however, surely we should all endeavour to find ways of getting maximal 'mileage' out of every penny spent.

Even if my good intentions wrongly came over as a 'stinging rebuke' it would be worthwhile if this helps refocus priorities.

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Bacterial vaginosis: not a risk factor for preterm birth?

Oakeshott *et al* failed to document an association between bacterial vaginosis in early pregnancy and subsequent preterm birth in their 37 community centre-based study.[1] They further suggest that the relative risk of preterm birth in women with vaginosis may have been overestimated in hospital-based studies due to patient selection. Since we lack population-based prevalence estimates of bacterial vaginosis,[2] the distinction between community- versus hospital-based risks may indeed be valid as has been suggested before.[3] We are, however, concerned about the take-home messages sent out to the general practitioner.[1]

The first reason is that this community-based sample seems to enjoy a preterm birth rate of 4.9%, and among black women an even more favourable preterm birth prevalence of 1.1%, considering the reference population (England) has a prematurity risk of at least one out of seven pregnancies.[4]

One can only speculate, though, why this sample selectively drawn from a London community was at apparently lower risk. Although the authors explain the differential risk by putting emphasis on studying a low-risk community-based cohort — as allegedly opposed to hospital-attending women — it must be acknowledged that their sample may not be quite representative of the community it was drawn from. Indeed, the authors actually recruited 1216 women from 37 centres over a 2-year period, suggesting that within each centre, less than two patients a month on average volunteered to enroll in the study.

Secondly, even if there was no genuine association between bacterial vaginosis at <10 weeks' gestation and preterm birth, the study may lack the power to substantiate this. Indeed, the 95% confidence interval on the relative risk of preterm birth stretches from 0.4 to 2.2 and contains the typical bacterial vaginosis risk estimate of 2, as recently shown in a systematic review on this subject.[5] In fact, for typical relative risk estimates of 1.5 and 2.0, this study has a power of 22.8% and 55.1%, respectively, to detect a significant effect at the 5% level. To document an overall relative risk of 2.0 with a power of 80%, at least 224 women with and 1494 women without bacterial vaginosis should have been included. Similarly, this community-based sample comprised 88 black Caribbean and black African women, accounting for merely two preterm births, and therefore this study did not allow risk stratification for ethnicity.

We therefore believe that methodological concerns prevent any firm conclusions being drawn from the study by Oakeshott *et al*.

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References

1. Oakeshott P, Kerry S, Hay S, Hay P. Bacterial vaginosis and preterm birth: a prospective community-based cohort study. *Br J Gen Pract* 2004; **54:** 119-122.
2. Morris M, Nicoll A, Simms I, *et al*. Bacterial vaginosis: a public health review. *BJOG* 2001; **108:** 439-450.
3. Gratacos E, Figueras F, Barranco M, *et al*. Prevalence of bacterial vaginosis and correlation of clinical to Gram stain diagnostic criteria in low risk pregnant women. *Eur J Epidemiol* 1999; **15(10):** 913-916.
4. Department of Health. *NHS maternity statistics, England 2001-2002.* Statistical Bulletin 2003/09. London: Department of Health, 2003.
5. Leitich H, Leitich H, Bodner-Adler B, *et al*. Bacterial vaginosis as a risk factor for preterm delivery: a meta-analysis. *Am J Obstet Gynecol* 2003; **189:** 139-147.

Authors' response

We agree that our study lacked power to look at the relationship between bacterial vaginosis in early pregnancy and preterm birth. It was originally designed to look at the relation between bacterial vaginosis and miscarriage before 16 weeks' gestation.[1] However, when we found that few women diagnosed with bacterial vag-inosis were being treated, we extended the follow-up period to look at preterm birth.

Verstraelen *et al* correctly point out that (as with many primary care-based studies) recruitment was a major challenge and varied widely between practices. Although participants were broadly representative in terms of age and ethnicity, there was a preponderance of women from higher socioeconomic groups. The main positive conclusion from our study is that screening for bacterial vaginosis and chlamydial infection using self-taken swabs is feasible even during pregnancy.

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References

1. Oakeshott P, Hay P, Hay S, Steinke F, Rink E, Kerry S. Is bacterial vaginosis or chlamydial infection associated with miscarriage before 16 weeks gestation? A prospective community based cohort study. *BMJ* 2002; **325:** 1334-1336.

Correction

In the June 2004 issue, in Smith L, Ernst E, Ewings P, *et al*. Co-ingestion of herbal medicines and warfarin (*Br J Gen Pract* 2004; **54:** 439–441), the following acknowledgement was omitted: This study was funded entirely by a grant from the Maurice Laing Foundation.