

abortions.<sup>1</sup> He concludes that this raises the "worrying question of whether girls in the most affluent areas are placed under undue social and parental pressure to terminate their pregnancies, possibly against their real wishes."

The text of the paper gives no support to this conclusion. Neither the girls nor their parents were asked about this: it is pure surmise. I wish to suggest an alternative interpretation.

Smith defines a pregnancy as unwanted if a legal abortion was obtained. There is evidence, however, that working class girls have greater difficulty in wending their way through the obstacle race to obtain the NHS abortions they desire.<sup>2</sup> He should perhaps have defined a pregnancy as unwanted if legal abortion was desired, not simply if it was obtained.

More important are social and cultural expectations. Affluent middle class girls have higher education, careers, and financial independence to look forward to. So becoming a teenage mother in error is not part of their plan. In this they are no doubt warmly supported by concerned parents who will help them find their way to a legal abortion if that is what they desire. Girls from deprived backgrounds, with little education and doing underpaid and repetitive jobs may find the notion of having a baby even at a very young age a more attractive proposition. Moreover, they know that they are not sacrificing much in terms of future prospects.

Smith is right to be concerned about reducing the risk of unwanted pregnancy. One way is greatly to improve access to effective health education and contraceptive services. Another is to give girls a motive for avoiding too early pregnancy by making further education attractive to them with the chance of a good job and independence at the end of it. Not too many teenage mothers are to be found in the ranks of women doctors, lawyers, social workers, scientists, business managers, school teachers, etc. It shows that it can be done.

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- 1 Smith T. Influence of socioeconomic factors on attaining targets for reducing teenage pregnancies. *BMJ* 1993;306:1232-5. (8 May.)
- 2 Simms M, Smith C. *Teenage mothers and their partners*. London: HMSO, 1986. (Department of Health and Social Security Research report No 15.)

### Seek the views of teenagers

EDITOR,—Smith's recent paper on socioeconomic factors in teenage pregnancy confirms some findings from our practice on a "forgotten" peripheral city estate.<sup>1</sup> Our practice covers a social class III and IV housing estate on the outskirts of Cardiff. We recently conducted a review of notes of teenagers and discovered a high rate of pregnancy.<sup>2</sup> Four out of 58 teenage girls' notes showed a termination in the calendar year 1991 (69 per 1000). None of the notes showed a pregnancy that continued to term. These figures are matched by data from an audit the previous year. This work complements that of Smith, which strongly supports the hypothesis that socioeconomic factors play a part in teenage pregnancy rates. Data from America seem to further confirm this pattern.<sup>3</sup> We suggest that termination rates from individual practices can be used when setting more localised and specific targets and allocating resources to reduce the numbers of teenage pregnancies that are truly unwanted.

We agree with Smith that discussion is complicated by there being no concrete information as to what constitutes better outcomes in the field of teenage pregnancy. American work suggests that the teenage girl who becomes pregnant can derive some social benefit in the form of showing to her parents her maturity and independence, coupled with a need for greater dependence on those

parents.<sup>4</sup> This may be one reason why we should not necessarily view teenage pregnancy as a bad outcome.

It is necessary to ask teenagers themselves if they view a pregnancy that ends in either birth or abortion as unwanted. Our lack of understanding regarding this may be part of a broader communication mismatch. For example, our review of the literature suggests that teenagers view other health problems such as acne or obesity as of immediate concern,<sup>5</sup> with sexuality given as a lower priority. Therefore the needs of the teenagers may be easily subsumed under the perceived need of the professionals to produce improved rates of "health" in the teenage population as a whole. This is especially likely to happen in light of the simplistic nature of the targets set by government in this complicated area of human health and behaviour. This communication aspect will need to be addressed if a joint agenda for improvements in teenage health care is to be created.

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- 1 Smith T. Influence of socioeconomic factors on attaining targets for reducing teenage pregnancies. *BMJ* 1993;306:1232-5. (8 May.)
- 2 Jacobson L, Owen P. Study of teenage care in one general practice. *BJ Gen Pract* (in press).
- 3 Voydanoff P, Donnelly B. *Adolescent sexuality and pregnancy*. London: Sage Publications, 1990.
- 4 Ringdahl E. The role of the family physician in preventing teenage pregnancy. *Am Fam Phys* 1992;45:2215-9.
- 5 Bewley B, Higgs R, Jones A. Adolescent patients in an inner London general practice—their attitudes to illness and health care. *J R Coll Gen Pract* 1984;34:543-6.

## Open access gastroscopy

### Service is efficient and effective

EDITOR,—R V Heatley has missed the point of open access gastroscopy.<sup>1</sup> Gastroscopy is "undoubtedly the most sensitive tool to investigate the upper gastrointestinal tract."<sup>2</sup> Heatley is concerned that there is no evidence to support the initial investigation of all dyspeptic patients by gastroscopy. No unit has proposed this or could come near to achieving it. General practitioners refer only about a tenth of patients seen with dyspepsia for assessment in hospital.

If open access gastroscopy is not available patients wait to be seen in a clinic, often by a junior doctor with less experience than the general practitioner. Most of them have gastroscopy after a further visit. The value of open access gastroscopy is that access to the most sensitive tool is gained quickly and general practitioners maintain clinical control of most patients with uncomplicated disease. Pressure on the clinic reduces so that more time can be given to patients who require assessment by a specialist. A patient can be referred to clinic in the traditional way if the general practitioner or patient prefers this. Two fifths of the patients with dyspepsia who are referred in our district are still sent this way, even though open access gastroscopy has been available for four years.

Our experience shows that open access gastroscopy is used responsibly.<sup>3</sup> Subsequent treatment by the general practitioner is appropriate to the findings in four fifths of cases, and only 14% of patients are referred for assessment by a specialist in the 12 months after gastroscopy (unpublished data). The waiting time for open access gastroscopy is less than three weeks, and the waiting time for the clinic has fallen dramatically.<sup>2</sup> Heatley quotes work showing a reduction in barium meal examinations associated with open access gastroscopy, and we can confirm that. This also showed low prescribing costs in practices with a high use of the service and

vice versa. Arguments about cost effectiveness must consider a wide range of interrelated factors both in and out of hospital.

Studies have failed to show that open access gastroscopy detects more ulcers and cancers. Attempts to increase the diagnostic yield by screening with a scoring system had limited success. Surely, gastroscopy is most valuable in those cases in which there is uncertainty rather than near certainty. It is false to judge appropriateness against the proportions found to be normal or abnormal. The gold standard is whether open access gastroscopy is helpful or unhelpful with subsequent management. This point has been emphasised recently.<sup>1</sup> Heatley finds it easy to justify using open access gastroscopy to look for cancer, but it is of limited value in this respect. In our series of almost 6000 patients who had open access gastroscopy only two fifths have had no abnormality, but less than 2% had cancer.

Open access gastroscopy is an efficient way of using limited resources. It does not preclude referral for assessment by a specialist. Care must be taken to organise and monitor the service to maintain efficiency and safety.<sup>2</sup>

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- 2 Bramble MG, Cooke WM, Corbett WA, Cann PA, Clarke D, Contractor B, et al. Organising unrestricted open access gastroscopy in South Tees. *Gut* 1993;34:422-7.
- 3 Najji SA, Brunt PW, Hagen S, Mowat NAG, Russell IT, Sinclair TS, et al. Improving the selection of patients for upper gastrointestinal endoscopy. *Gut* 1993;34:187-91.

### GPs use gastroscopy appropriately

EDITOR,—R V Heatley's editorial uses a perfectly valid argument to come to the wrong conclusion.<sup>1</sup> He is of course right to point out that there is insufficient evidence of the value of endoscopy to justify investigating all dyspeptic patients endoscopically. His error is in assuming that general practitioners are not selective in their use of this investigation—and, by implication, that gastroenterologists are. Experience tells me otherwise.

There is ample evidence that general practitioners are discriminating in their use of radiology,<sup>2</sup> even when compared with hospital doctors.<sup>3</sup> There is no reason to believe that hospital doctors use endoscopy differently from radiology. My own perception of gastroenterological services is that hospital doctors are much less discriminating than general practitioners in selecting patients for endoscopy. Not only is everyone given endoscopy, but the process is often repeated "to ensure healing" in duodenal ulcer patients who are totally symptom free after treatment.

With regard to the cost-benefits of general practitioners' open access, there is evidence in respect of radiology and endoscopy that "open access appears to save outpatient consultations."<sup>4</sup> This all assumes, of course, that endoscopy is an effective and valid diagnostic test. No one really doubts that, but if it were ineffective and invalid this would be a reason to stop using it altogether, not for restricting its use to gastroenterologists.

If a specialist can be allowed to preach to general practitioners on their role, I hope I can be forgiven for preaching to a specialist. I believe that an important part of the specialist role is teaching other doctors (both general practitioners and specialists) the appropriate use of the services they offer. I would not be in the least put out if a pathologist, radiologist, or even gastroenterologist were to tell me that I was using their service inappropriately, particularly if they were to improve my understanding of the issues and my

management of subsequent problems. It is not possible to construct such care guidelines without dialogue, however, since the specialist needs to understand the nature and dimensions of the problem outside the hospital to produce valid advice for use in that environment.

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- 2 Wright HJ, Swinburne K, Inch J. The general practitioner's use of diagnostic radiology. *J R Soc Med* 1979;72:88-94.
- 3 Haines AP, Ashleigh R, Baker R, Kreef L. The use of barium meals by general practitioners and hospital doctors. *J R Coll Gen Pract* 1980;30:97-100.
- 4 Barton E, Gallagher S, Flower CDR, Hanka R, King RH, Sherwood T. Influence on patient management of general practitioner direct access to radiological services. *Br J Radiol* 1987;60:893-6.
- 5 Hunjin AS. Use of an open access gastroscopy service by a general practice. Findings and subsequent referral rate. *J R Coll Gen Pract* 1987;37:170-1.

### Open access means overinvestigation

EDITOR.—R V Heatley questions the appropriateness of open access endoscopy, pointing out that the management of dyspepsia is mainly empirical.<sup>1</sup> We agree with Heatley's concerns. Open access endoscopy has often been justified on the basis that general practitioners are as good as hospital doctors at referring patients in whom endoscopy yields positive findings.<sup>2</sup> Though this is true, the suggestion that positive findings influence management remains to be proved. Such confused thinking leads to unnecessary and ever increasing investigation.

In Tower Hamlets an open access endoscopy service was introduced in October 1990. This proved popular, and the number of endoscopies performed monthly rose, reaching 51 in September 1991. We hoped that this would result in a fall in the number of barium meal examinations requested by general practitioners and in resultant ionising radiation. But no significant fall could be shown in the following year: the mean (SD) monthly rate of barium meal examinations for the five months before open access was introduced was 85.6 (19.3) and that for the same period a year later was 67.6 (9.6) ( $t=1.87$ ,  $p>0.05$ , Student's  $t$  test).

Unfortunately, endoscopists have not learnt the lessons from the mistakes of radiologists. An open access service for barium meal examinations was encouraged over a decade ago on the basis of the rate of positive findings in patients referred by general practitioners.<sup>3</sup> It has become clear, however, that most of these investigations have no substantial effect on management, particularly in younger patients.<sup>4</sup> It is less excusable that these mistakes are being repeated now that audit has become so important and there is much greater awareness that empirical management is often appropriate.<sup>5</sup> There is a danger that, like the radiologists of the past, endoscopists will be carried away by the popularity of open access services.

We would make a plea for cooperation between gastroenterologists and radiologists to reduce unnecessary investigation. Appropriately enforced guidelines that have been agreed with general practitioners are a possible approach. The sooner we convince general practitioners that we wish to avoid unnecessary tests rather than promote our own techniques the better it will be for patients.

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- 1 Heatley RV. Open access upper gastrointestinal endoscopy. *BMJ* 1993;306:1224. (8 May.)
- 2 Kerrigan DD, Brown SR, Hutchison GH. Open access gastroscopy: too much to swallow? *BMJ* 1990;300:374-6.

- 3 Haines AP, Ashleigh R, Bates R, Kreef L. The use of barium meals by general practitioners and hospital doctors. *J R Coll Gen Pract* 1980;30:97-100.
- 4 Conry BG, McLean AM, Farthing MJG. Diagnostic and therapeutic efficacy of barium meal examination: a prospective evaluation in general practice. *BMJ* 1989;299:1443-5.
- 5 Brown C, Rees WDW. Dyspepsia in general practice. *BMJ* 1990;300:829-30.

## Accident and emergency in London

### Better primary care won't affect self referrals

EDITOR.—The results of Raymond F Jankowski and Sundhiya Mandalia's study suggest that reforms in primary health care following on from the Tomlinson report may not, as has been presumed, reduce the workload of accident and emergency departments.<sup>1</sup> To assess the generalisability of their findings we examined the source of referral for 42 663 patients aged 16 and over who attended the accident and emergency department of University College Hospital, London, during 1992. The data were obtained from the TRACE pharmacoepidemiological database, which contains demographic, diagnostic, and therapeutic details of all attendances.

We found fewer referrals from general practitioners (9.3%) and self referrals (60.6%) than expected (Jankowski and Mandalia found 12.4% and 66.7% respectively) but higher proportions of referrals from the workplace, police, and "other" (table). As we were concerned that the group classified as "other" might have consisted of genuine self referrals we examined 200 random records to obtain more information. This inspection showed that about half of the "other" referrals could be reclassified as self referrals, but the remaining half were either people who had been taken to the accident and emergency department by ambulance or people who had been urged to seek medical advice by an unrelated person. Further analysis confirmed that "other" referrals were perceived as more urgent by the source of the referral as 4290 (55.3%) of the patients arrived by ambulance compared with 2916 (11.3%) for self referrals.

We also classified patients who attended by whether they were local residents, non-local residents, or homeless (based on postcode) because this department is in an area with a large proportion of commuters and tourists. Where this information was inadequate we used the classification "not known" (<5%). The proportion of people attending who were non-local residents was high (48%). After all the local residents in the "other" referral category were reclassified to the self referral category the revised self referral rate was 68.1% (95% confidence interval 67.6% to 68.5%)—remarkably similar to Jankowski and Mandalia's finding (66.7%). We intend to carry out more detailed analyses of diagnostic information to determine the appropriateness of attendance at the accident and emergency department.

Central London is atypical in that a large

proportion of the workload is generated by commuters, tourists, and homeless people who consult an accident and emergency department when they become ill. Clearly, improvements in primary health care based in general practice, although welcome, will not have any great effect on the consultation patterns of these groups. Other initiatives, such as open access primary care, may well have an impact on the workload of nearby accident and emergency departments. Such effects will require careful monitoring with sophisticated information systems.

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### Patients' perceptions are the problem

EDITOR.—Attendances at accident and emergency departments have been rising by over 1% a year over the past decade.<sup>1</sup> The Tomlinson report and a recent King's Fund report state that the increase in the London area is likely to be due to the poor provision of primary care in the community.<sup>2,3</sup> Raymond F Jankowski and Sundhiya Mandalia state that data confirming this perception were largely unavailable.<sup>4</sup> The results of a survey conducted in an inner London accident and emergency department may be of interest. The results are from a questionnaire study of 587 "non-urgent" patients (who could wait over an hour for treatment) attending St Bartholomew's accident and emergency department over a four week period. These patients were asked if they expected the following: to see a doctor; to have an x ray examination; to need a dressing; to need a prescription. They were also asked if they had contacted their general practitioner and also if they thought their general practitioner could cope with their problem.

In all, 22.5% of patients did not expect to see a doctor. Only 38% thought that their general practitioner could cope with their problem; 84% had not contacted their general practitioner before attending the department. An x ray, tablet, or dressing was expected by 46%, 48%, and 27% of patients, respectively. The majority of patients did not expect an x ray examination, so this is not the principal reason for attendance at the department. No attempt was made to define the socio-demographic data of the patients questioned, so it is not possible to say if these patients were commuters, tourists, or local inhabitants.

These "non-urgent" patients perceived the accident and emergency department as the most suitable point of access for the treatment they expected. An appreciable number did not think a doctor was necessary. A nurse practitioner or

Attendances at University College Hospital's accident and emergency department in 1992 by source of referral and residence status (figures in parentheses are percentages)

Source of referral	Local resident	Non-local resident	Homeless	Not known	Total
Self	11 040 (25.9)	12 506 (29.3)	1064 (2.5)	1227 (2.9)	25 837 (60.6)
Own general practitioner	2 695 (6.3)	1 095 (2.6)	17 (0)	149 (0.3)	3 957 (9.3)
Workplace	670 (1.6)	2 413 (5.7)	6 (0)	120 (0.3)	3 209 (7.5)
Other hospital	73 (0.2)	79 (0.2)	7 (0)	1 (0)	160 (0.4)
Police	423 (1.0)	679 (1.6)	241 (0.6)	109 (0.3)	1 451 (3.4)
Social services	19 (0)	5 (0)	1 (0)		25 (0.1)
Schools	9 (0)	20 (0)			29 (0.1)
Other	3 210 (7.5)	3 575 (8.4)	508 (1.2)	464 (1.1)	7 757 (18.2)
Not known	94 (0.2)	93 (0.2)	29 (0.1)	22 (0.1)	238 (0.6)
Total	18 233 (42.7)	20 465 (48.0)	1873 (4.4)	2092 (4.9)	42 663 (100.0)