Table 1—*All cause mortality ratios* (95% confidence intervals) adjusted for socioeconomic status among second generation Irish people in England and Wales at working ages† during extended period of follow up (1971-92)*

	Women		Men	
	Standardised mortality ratio	No of deaths	Standardised mortality ratio	No of deaths
Mortality adjusted for:				
Age	126 (103 to 152)‡	104	124 (110 to 140)‡	267
Age and social class I-IV§	134 (103 to 170)‡	67	129 (111 to 149)‡	184
Age, housing tenure, and access to car	126 (102 to 152)‡	102	122 (107 to 138)‡	247

*Relative to all men or all women (standardised mortality ratio = 100).
†Ages 15-64 for men, 15-59 for women.
‡Standardised mortality ratio significantly different from 100 at 5% level.
§First five years of follow up were excluded to allow for health selection.[2]

one or both parents born in the Republic of Ireland represents not only a possible genetic contribution but, importantly, the effect of lifestyle and cultural factors ("ethnic features") that could persist across generations. We consider variation in lifestyle factors to be an integral part of ethnic analysis and likely to be a major contributor in this case.

While we agree with Fielder and colleagues that health problems of second generation Irish people are not comparable with those of population groups for whom language and culture may cause difficulties in access to health care, this does not rule out the fact that Irish people may have problems different from those of the majority population. This would apply not only to second generation but also to first generation Irish people.[1] How can it be wrong to direct time and effort to this group when an opportunity to achieve considerable health gains exists?

We disagree with Fielder and colleagues that if concerted efforts were made to address health problems connected with socioeconomic deprivation in the whole population then the issue of the health of Irish people would be addressed. Though socioeconomic status is important, it cannot explain the excess mortality shown in table 1.

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1 Adelstein AM, Marmot MG, Dean G, Bradshaw JS. Comparison of mortality of Irish immigrants in England and Wales with that of Irish and British nationals. *Ir Med J* 1986;79:185-9.
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Going home after a heart attack

Patients should visit their general practitioner, not vice versa

EDITOR,—Doubtless H J N Bethell is correct in stating that there is much that can be done in primary care for patients recently discharged after having a myocardial infarction.[1] Nevertheless, in the context of current efforts to delegate some of the average general practitioner's ever increasing workload and to encourage patients to attend the surgery rather than expect a visit, Bethell's assertion that general practitioners should visit these patients soon after discharge is disappointing.

There is no reason why a suitably trained nurse practitioner could not undertake all the tasks that Bethell outlines. Nor is there any reason why, in most cases, the patient could not attend the general practitioner's surgery. Ironically, expecting the general practitioner to visit runs counter to the rehabilitation process. Surely a patient who is fit enough for sex within a week or two of arriving home ("unless it is with an unfamiliar partner"[1]) is fit enough to consult at the surgery (unless, perhaps, it is with an unfamiliar doctor).

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1 Bethell HJN. Going home. *BMJ* 1996;312:1372-3. (1 June.)

Depression is also a risk factor

EDITOR,—H J N Bethell's editorial on care after myocardial infarction omits to mention depression, particularly in the list of factors that increase risk.[1] This is surprising, as depression is known to be an "independent risk factor for mortality at six months. Its impact is at least equivalent to that of left ventricular dysfunction ... and history of previous myocardial infarction,"[2] its effects being at least partly mediated through further myocardial ischaemia.[3]

Depression after myocardial infarction is often chronic[4] and associated with non-compliance with treatment and with refusal of rehabilitation programmes. It is diagnosed and treated much less frequently than would be the case if the patients were free of physical illness.[5] This is probably because doctors perceive a lack of effective treatments. It is likely, however, that rehabilitation is effective, at least partly through an effect on psychological symptoms, and psychological treatments should be used if available. Few trials of antidepressant drugs have been carried out in these patients, but the risks of using such drugs have probably been exaggerated.[5] High quality trials of these treatments are urgently needed.

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Women with urinary incontinence should be referred to a specialist

EDITOR,—Arnfinn Seim and colleagues give some useful reminders about improvements that can be achieved by treating urinary incontinence in women in general practice.[1] At the end of their study, however, 80% of the women were still incontinent to some extent. It is interesting that only 16% of the patients were referred for specialist opinion. In the long term it may be better for patients to be referred for expert diagnosis and treatment, to avoid some of the long term financial and social burdens of prolonged incontinence.[2] When the prospect is many years of incontinence (the youngest patient was only 20 years old) a referral to a specialist—who can perform urodynamic tests, make an accurate diagnosis, and devise a management plan—is preferable to making an unsupported diagnosis and providing treatment that may be inappropriate. Obtaining a good clinical history of bladder disorders is known to be difficult, so if treatment is to be based on the history alone then treatments that are effective in both common forms of incontinence (genuine stress incontinence and detrusor instability) are probably more appropriate—for example, pelvic floor exercises.[3]

The trial was undoubtedly performed by a team interested in this subject and method of treatment, and I suspect that the results would not be as good if the trial was repeated by a less enthusiastic set of practitioners. Although, as a hospital urogynaecologist, I would not like to see my urodynamic clinics overrun, I would like more than 20% of patients to become fully continent.

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Interventions in childbirth

Medical intervention is not synonymous with loss of dignity

EDITOR,—In her effort to empathise and share the experience of childbirth with her daughter in law, Ann Oakley (a professor of social science) offers a one sided view of care in labour.[1] I can assume only that her personal involvement has caused her to be unable to appraise the event with objectivity or professionalism.

Although, as a sociologist, Oakley has witnessed many labours, she repeatedly misinterprets the best of professional intentions. Obstetric practice may well have had—and probably still has—shortcomings. But in describing former practices that were attempts to minimise the incidence of puerperal sepsis as "dehumanising" Oakley does not sufficiently consider the reasons for the practices and implies intent to take away the dignity of the labouring mother. The idea of doctors "hovering with their forceps outside the door" having to be overcome by midwives brings images of bizarre behaviour to mind. Does Oakley really believe that obstetricians would choose to lose sleep rather than lose