Should general practitioners carry aspirin in their bags? The answer is no.

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Services for people with haemoglobinopathy

EDITOR,—Sally Davies has expressed her concern, which I share, on the quality and quantity of services available to patients with sickle cell anaemia, as compared with those available to patients with other inherited disorders.[1] I find it pertinent to note how much population genetics can affect public health.

With a heterozygote (AS) frequency of about 16% in the 885 000 black people in the United Kingdom, the predicted number of patients with homozygous sickle cell anaemia (SS) is 5834, based on the implicit assumption that intermarrige takes place only among black people.[2] On the other hand, the AS heterozygote frequency in the population of England and Wales (49·9 million) is about 0·3%, and under the hypothesis of random mating the corresponding predicted number of SS patients would be 98. Thus, the prevalence of a recessive genetic disorder depends dramatically on breeding patterns.

The single change that could most rapidly and drastically affect the frequency of sickle cell anaemia in Britain would be based on sociology rather than on medicine or molecular biology: if random mating applied, sickle cell anaemia would become much more rare than cystic fibrosis or phenylketonuria. Similar considerations apply to β thalassaemia.

Until such sociological changes take place, it seems likely that in the near future the number of SS patients will be much nearer 6000 than 100. Thus, provision of adequate services is imperative for a number of this magnitude. Indeed, we have a dual obligation to patients with these disorders: because they have a severe disease and because they carry the genetic load that has enabled human populations to survive in areas where malaria is endemic.

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Outreach clinics in general practice

EDITOR,—The medical press has widely reported that outreach clinics do not seem to have improved communication between general practitioners and specialists. In the case of fundholding practices this conclusion cannot be drawn from the paper by Jacqueline Bailey and colleagues, who measured only how often general practitioners attended outreach clinics.[1] There are many more efficient ways of communicating and learning than attending clinics. In my practice, which has five in house clinics, specialists discuss their cases over a working lunch attended by all partners and the practice's clinic nurse. We think that communications have improved greatly.

Bailey and colleagues state that fundholders had initiated their clinics. Presumably they arranged to communicate with specialists at other times. In the table showing the advantages to fundholders of outreach clinics, communication with specialists was mentioned most commonly and educational value was second. The outreach clinics have probably led to improved communications, but the authors' assessment based solely on general practitioners' attendance failed to show this.

A further weakness of the paper is that it compares the incomparable. The result is meaningless. Outreach clinics set up in health centres during the 1970s largely by psychiatrists are simply collocations of services. They cannot be compared with in house clinics set up recently for other specialties in fundholding practices. In house clinics have resulted in better use of resources by improving the accuracy of referral and reducing unnecessary review. The clinics are popular with patients, who find them convenient and like the familiar setting. In our experience they lead to improved communications and better clinical management.

Studies such as Bailey and colleagues' are of limited value. What matters are the maximum achievable benefits of outreach clinics. Once the benefits and how to achieve them are understood, outreach and in house clinics will become widespread.

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1 Bailey J, Black ME, Wilkin D. Specialist outreach clinics in general practice. *BMJ* 1994;308:1083-6. (23 April.)

Authors' reply

EDITOR,—Though we have no doubts that some outreach clinics have resulted in improved communication between general practitioners and specialists, the findings of our national survey do not suggest that such benefits are widespread. We illustrated this by reference to the fact that general practitioners rarely attended clinics. Other evidence from our study, not included in the original paper, supports our general conclusion. Forty six (79%) fundholders and 25 (91%) nonfundholders did not have regular meetings with specialists. James A Dunbar and colleagues' observation that many fundholding practices had initiated outreach clinics has no necessary bearing on subsequent levels of communication. Though it is true that many general practitioners and specialists identified communication as a potential benefit of outreach clinics, a gap seems to exist between aims and reality.

Dunbar and colleagues' objection to our inclusion of clinics established before 1990, on the grounds that they consisted largely of psychiatric clinics established for reasons of collocation of services, is not supported by the evidence. Firstly, many clinics in psychiatry have been established with the explicit objective of improving liaison with general practitioners.[1] Secondly, we found that 21 of the 45 clinics established before 1990 were in medical and surgical specialties.

Unfortunately, there is no evidence to support Dunbar and colleagues' assertion that outreach clinics result in better use of resources through improved referral, the reduction of unnecessary review, and better clinical management. In our study 35 (61%) fundholders and 25 (90%) nonfundholders reported that there had been no effect on numbers or types of referrals and 17 (29%) fundholders reported an increase. Only eight (11%) specialists reported that they received more appropriate referrals. Twenty six (94%) nonfundholders and 38 (65%) fundholders reported that there had been no effect on follow up.

Dunbar and colleagues fail to acknowledge the potential problems associated with outreach clinics, including use of specialists' time, access to investigation and treatment facilities, and the provision of hospital cover.

In the light of our results it would be unwise to emphasise the maximum achievable benefits as Dunbar and colleagues suggest. Outreach clinics are becoming widespread, but there is limited evidence of what the potential benefits are and even less of how to achieve them. Despite its limitations our study of the current spread of outreach clinics and the views of the general practitioners and specialists concerned provides a powerful case for further research to establish the clinics' cost effectiveness. Without such evidence the continuing debate between the proponents of outreach clinics and their detractors is unlikely to be resolved.

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1 Creed F, Marks B. Liaison psychiatry in general practice: a comparison of the liaison-attachment and shifted outpatient clinic models. *J R Coll Gen Pract* 1989;39:514-7.

Need proper evaluation

EDITOR,—Though highly thought provoking, the survey of specialist outreach clinics in general practice reported by Jacqueline J Bailey and colleagues was potentially misleading.[1] In particular, it seems entirely wrong to conclude that "there was little direct contact between general practitioners and specialists" simply on the grounds that only 6% of general practitioners attended the specialist clinics. It was also unfortunate that different specialties were lumped together, as satisfaction with services may have varied greatly.

The description of such services as "outreach clinics" implies a rigid and hierarchical relation between primary and secondary services and emphasises geographical rather than conceptual change. In psychiatry, where even attending an outpatient department may be stigmatising, it is recognised that the essence of any primary care attachment is liaison between professionals. While it is unlikely that a busy general practitioner would have time to attend a specialist clinic, the survey may well have overlooked the frequent but informal sort of patient centred liaison which allows general practitioners to provide continuing care for their patients, rather than handing over this responsibility to a speciaist. That 40% of clinics were unknown to hospital managers suggests that many attachments may have arisen through informal negotiation between general practitioners and specialists.

Andrew Harris is absolutely right to call for proper evaluation of specialist attachments in primary care,[2] particularly in view of the resource implications of unrestrained growth.[3] The introduction of fundholding means that general practitioners no longer depend on local specialists to provide services they feel their patients need.