relation between stress and smoking, suggesting that smoking relieves the stress of smoking withdrawal but that completely stopping smoking tends to lead to reduced stress, with stress increasing if smoking is resumed.^{33,34} This may mean that providing support for stopping smoking, such as nicotine replacement, would be more effective than expected. More direct policies might be considered, to use some of the additional revenue from higher cigarette taxes to compensate poor lone parents for the increased cost of living caused by the taxes. Thus, increased cigarette prices could provide a good incentive to stop smoking, while the increased income support would prevent penalisation of those unable to stop smoking. The increased support given to people who continued to smoke would be clawed back in cigarette tax.

CONCLUSION

Changes in cigarette prices seem to have had a strong impact on smoking; the greatest impact is on groups that are least responsive to health publicity measures but have the highest prevalence of smoking. This suggests that real increases in the price of cigarettes will both reduce smoking and help to reduce the differences in the prevalence of smoking and smoking related diseases between socioeconomic groups. Special measures are necessary to ameliorate any effects on the cost of living of the most deprived families.

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Promotion of family planning services in practice leaflets

M N Marshall, D J Pereira Gray, V Pearson, D R Phillips, M Owen

Institute of General Practice, Postgraduate Medical School, University of Exeter, Exeter EX2 5DW
M N Marshall, research fellow
D J Pereira Gray, professor

Department of Public Health Medicine, Dean Clarke House, Southernhay East, Exeter EX1 1PQ
V Pearson, senior registrar
M Owen, consultant in public health

Institute of Population Studies, University of Exeter, Hooper House, Exeter EX4 6DT
D R Phillips, director

Correspondence to:
Dr Marshall.

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General practitioners provide about three quarters of the family planning services in the United Kingdom, so potential users should be aware of the services offered by their practice. All general practices are now required to produce leaflets to describe the contraceptive services provided.¹ As leaflets are generally well received by patients² and influence patient behaviour,³ they could be a useful information source for many aspects of family planning. We analysed the information about family planning in practice leaflets.

Methods and results

The leaflets are held by the Devon Family Health Services Authority and were assessed by one of us (MNM). We used criteria representing quality indicators for assessment (table), allocating one equally weighted point for each of the criteria mentioned and adding them together to give a score for each practice. These scores were related to the number of partners, the presence of female partners, and whether the practice was approved to train general practitioners.

Overall, 175 (88%) practice leaflets from 198 practices in Devon were available for analysis. Of these, 50

(29%) were from training practices and 82 (47%) from practices with one or more female partners. For the 10 criteria the leaflets achieved a median score of 2. Large practices had higher scores than small ones. The most commonly mentioned criteria were reference to the service and encouragement to use it, mention of when and what services were available, and the offer of a choice of provider within the practice. Few practice leaflets referred to postcoital contraception, confidentiality, or other sexual health issues.

Large practices were significantly more likely than small ones to mention family planning (χ^2 for trend 5.94, $P < 0.02$), to encourage the use of the service (16.74, $P < 0.001$), and to advertise a range of services (5.98, $P < 0.02$). Practices with female partners were significantly more likely to score above the median than all-male partnerships (χ^2 9.3, $P < 0.01$). There was no significant difference between the scores for training and non-training practices.

Comment

The findings suggest that leaflets are not being best used to advertise the range and potential of family planning services, which are separately contracted

Detail	No of partners (total No of practices)			Total (n=175)
	1 (27)	2 or 3 (71)	≥ 4 (77)	
Median score (range) achieved for 10 (95% confidence intervals)	2 (0-5) (1 to 2)	2 (0-7) (1 to 3)	3 (0-7) (2 to 4)	2 (0-7)
No (%) of leaflets with criterion:				
Family planning mentioned	21 (78)	64 (90)	73 (95)	158 (90)*
Family planning encouraged	2 (7)	16 (22)	35 (45)	53 (30)†
Methods other than pill offered	8 (30)	24 (34)	40 (52)	72 (41)‡
Choice of provider inside practice offered	8 (30)	31 (44)	30 (39)	69 (39)
Choice of provider outside practice offered	0 (0)	2 (3)	7 (9)	9 (5)
Service availability (for example, special clinic) described	8 (30)	31 (44)	32 (42)	71 (41)
Postcoital contraception mentioned	0 (0)	2 (3)	3 (4)	5 (3)
Partner encouraged to attend	0 (0)	0 (0)	3 (4)	3 (2)
Confidentiality mentioned	2 (7)	3 (4)	5 (6)	10 (6)
Other issues mentioned (for example, AIDS, termination of pregnancy)	0 (0)	3 (4)	4 (5)	7 (4)

Significant differences with χ^2 for trend: *P=0.015; †P=0.00004; ‡P=0.014.

but available within general practice. All practices in Devon offer contraceptive services, but one in 10 leaflets did not mention family planning. The lack of reference to postcoital contraception and information about services outside the practice for people who might not want to see their family doctor supports the need for more information for patients and corresponds with findings suggesting that patients attending their general practitioner were less knowledgeable than those attending family planning clinics.⁴

Group practices and those with female partners are most likely to give high priority to family planning issues in their leaflets. All practices could enhance their leaflets by encouraging members of the practice team to contribute and by working closely with other interested parties.

This study has limitations. Twenty three (12%) practices seemed to have submitted no leaflet to the

family health services authority. These practices were informed of their omission; they were not significantly different from those that had submitted one in terms of size of partnership or health district. Our assessment criteria could be criticised as arbitrary and too detailed, and we did not rank their importance. Some issues, such as an explicit statement of confidentiality, might be more important to certain people, such as those under 16.

Leaflets are not the only or necessarily the best medium to advertise services, and some practices may be using other means. Certainly, low scores do not indicate a lack of service, but if the aims of the *Health of the Nation*⁵ are to be achieved general practitioners need to keep their patients informed using as many means as possible. The risk of information overload in long leaflets should be considered. Our findings should encourage practices to update their leaflets and review the health promotion information in them.

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A MEMORABLE PATIENT

Divine intervention?

A patient with severe asthma, whom I saw in the early 1960s, stands out in my memory. She was a married woman of about 30 who had suffered from asthma almost continuously since her childhood.

She had severe airflow obstruction, much of which was irreversible by any treatment. When I first met her she had already become partially disabled by shortness of breath, making it difficult for her to look after her three children. For several years she had been taking a high dose of prednisone, but it had not given adequate control of her asthma and had induced marked Cushingoid features. During the year or two after I first met her, her peak expiratory flow was never higher than 190 l/min (40% of the mean predicted value for a woman of her age and height).

In spite of her increasing disability, she made little complaint. She was happily married and derived great joy from her three daughters, though she did not conceal her sadness that she had never had a son. This desire could now never be fulfilled, since she had been sterilised after her third pregnancy about five years previously. Though she was a devout Roman Catholic, she had agreed to sterilisation for the sake of her family, though her conscience had been troubled ever since the operation.

The sterilisation had been performed by an eminent gynaecologist, sometime president of the Royal College of Obstetricians and Gynaecologists. The reason given was that she would have great difficulty in looking after her three children without having another one. There had been no concern that a further pregnancy might be dangerous or cause adverse effects on her asthma; indeed,

during each of her previous pregnancies she had had a partial but shortlasting remission.

I was greatly surprised when, at a routine follow up appointment, her peak expiratory flow had risen to 260 l/min. This prompted me to remark that, had I not known that she had been sterilised, I might have thought that she was pregnant. At once it was clear that she too had wondered whether she could have conceived, for she then said that she had missed two periods and that recently her asthma had been less troublesome.

In due course a pregnancy test was reported to be positive. She expressed no surprise on being told the result and said that she could not have conceived without divine intervention.

While it might have been medically correct to advise termination of the pregnancy, it would have been wholly inappropriate and, in any case, she would never have agreed to it, for she was now certain that she would be given the son for whom she longed.

The pregnancy proceeded uneventfully and she had a normal delivery of a boy. Within a few weeks, however, her asthma became as severe as it had ever been, but her husband and daughters shared in her happiness over her newborn son and helped her to look after him.

A few months after the birth I left the clinic, but from time to time I inquired about the patient and her family from my successor. In the course of the following two years her asthma continued to deteriorate and she died in chronic respiratory insufficiency.—IAN GREGG is a retired physician in Southampton