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Quality of medical care is improved by use of structured questionnaires

Medicine has many effective interventions and there fore studying ways to prevent errors of omission has become increasingly important. Audit is based on past performance, but it is best to prevent mistakes before they occur. On p 1181 Lilford *et al* report a randomised study showing that structured histories result in improved medical practice. Clinically indicated actions were carried out more often when detailed questionnaires rather than unstructured forms were used to obtain antenatal histories. Contrary to the authors' previous expectations, computerised histories did not result in improved practice when compared with histories taken using a detailed manual questionnaire and checklist. However, more elaborate computer systems, which take in data at different stages of a patient's progress through the health service, could alert staff when they have failed to respond to risk factors. Evaluating the operational effects of such comprehensive computer systems is the next step in this research.

Policy for controlling pain after surgery

It is not always necessary to use esoteric methods of pain relief to obtain useful improvements in effect. Gould and colleagues (p 1187) have shown that the gradual and controlled introduction of different methods of analgesia to specific surgical wards can be used to demonstrate the individual effects of each. By referring to a guideline, nurses used sedation and pain scores to determine the timing of the next dose of analgesic. The increase in frequency of intramuscular injections of morphine that resulted brought. clear benefits to patients. The subsequent use of other methods had less pronounced effects. There was evidence that the benefits had spread to other wards in the hospital by the end of the study, and management decided that the benefits of an acute pain team justified new expense.

"White coat" hyperglycaemia

Doctors caring for patients with diabetes are often faced with the dilemma of clinic blood glucose concentrations which are higher than those reported from self monitoring. On p 1194 Campbell *et al* report that such patients can be classified into two broadly equal groups. In half the patients they studied, the glycaemic discrepancy could be explained by errors in monitoring technique, which were often related to cognitive or physical impairments. In the remainder, there was a transient glucose rise not found in the home environment and not attributable to the venepuncture procedure alone. The rise seemed to be due to the stresses of attending the clinic, analogous to white coat hypertension. Although serum fructosamine concentration can indicate the patient's true glycaemic control, it is usually not available at the time of the clinic visit.

Compliance with antenatal protocols

Risk factors detected at the antenatal booking visit to hospital determine the management of the pregnancy and standards of antenatal care. Compliance of protocols generated by a clinical information system at Homerton Hospital, London, was evaluated by Yoong *et al* (p 1184). They found poor compliance—less than a quarter of risk factors identified during history taking were acted on by consultants. Factors associated with improved compliance included early booking, older age of mother, black ethnic origin, and uncertainty of gestation.

Infant mortality in army families

To see whether the higher rate of infant mortality in Salisbury health district was attributable to higher rates among soldiers' infants Kimmance and Waters (p 1197) conducted a case-control study matching each child born in a hospital in the district and dying under 1 year with two of the same age and sex still living in the district at the death of the case. Fourteen of the 91 cases (18%) had fathers who were soldiers compared with 10 of the 182 controls (5%). The differences did not seem to be explained by mothers' ages or birth weights, and the authors remain puzzled by the finding.

Recognising and managing depression in general practice

Most depressed people never see a psychiatrist but are managed by general practitioners. On p 1198 Paykel and Priest summarise the findings of consensus conferences run by the royal colleges of psychiatrists and general practitioners to review advances in diagnosing and managing depression. Major depression is defined as depressed mood and four or more of seven concomitant symptoms, but lesser forms of depression are even more prevalent and easy to miss. Doctors who listen well and ask direct questions with a psychological and social content are more likely to detect depression. Tricyclic antidepressants at daily doses of 125-150 mg are effective in moderate to major depression. In milder cases counselling and social support can help as well as cognitive therapies.

Reducing doctors' hours

The Oxford region has used the new deal on junior doctors' hours as a spur not only to reducing hours but also to improving training and quality of service. Using a target that each job should have 50% of the time spent in training, Bulstrode and others (p 1203) show that this demands six people to run either a full or partial shift and five to run an on call rota in a support specialty (with all leave agreed in advance). Consultant sessions at non-standard times, such as evenings, increase greatly the amount of training time available for juniors and may also reduce the need for work to be done after midnight.