is made, adequate below knee support stockings may improve the symptoms and reduce the late sequelae. Some patients may benefit from ligation of the calf perforating veins, but there is no cure for deep venous incompetence; venous valve grafts are being evaluated but are not of proved benefit.

Valves occur most frequently in the popliteal and calf veins, and hence thrombosis in the lower leg and subsequent recanalisation are more likely to lead to deep venous incompetence than is thrombosis in the proximal limb—as witness the fact that tibial fractures lead more frequently to postphlebitic legs than do femoral fractures.[3] Similarly major thrombosis of the iliac vein is no more likely to lead to postphlebitic legs than are the smaller distal thromboses.[4]

Aitken and his colleagues recently showed how common the postphlebitic leg was in patients with a previous leg fracture by studying them many years later.[5] No fewer than half of 60 patients studied at least 15 years after the fracture had the symptoms and signs of the postphlebitic leg; conversely only 4% had symptoms and 24% signs in the unaffected leg. Given that the syndrome may take a considerable time to develop it is clearly much more frequent than had been thought; nor is the problem confined to the elderly: young patients are also vulnerable. Although those aged under 25 have a lower incidence of thrombosis, thereafter the frequency is unrelated to age.[3] Hence doctors should consider a more aggressive approach to using anticoagulants in young patients with fractures of the legs. This was suggested in the early 1960s[6] but has rarely been implemented, presumably owing to the low incidence of pulmonary emboli and the fear of bleeding problems. Prophylactic subcutaneous heparin has been less effective in orthopaedic procedures than in general surgery,[7] but heparin together with dihydroergotamine, or adjusted doses of heparin, dextran, and warfarin have given more encouraging results.

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1 Helmstedt A, Bergvall U. Phlebographic study of the incidence of thrombosis in the injured and uninjured limb in 55 cases of tibial fracture. *Acta Chir Scand* 1968;134:229-34.
2 Helmstedt A, Bergvall U. Recanalisation of deep venous thrombosis of the lower leg and thigh. *Acta Chir Scand* 1968;135:219-224.
3 Helmstedt A, Bergvall U. Incidence of thrombosis in patients with tibial fracture. *Acta Chir Scand* 1968;134:209-18.
4 Browse NL, Clemenson G, Lea Thomas M. Is the post-phlebitic leg always post-phlebitic? *Br Med J* 1980;281:1167-70.
5 Aitken RJ, Mills C, Immelman EJ. The post-phlebitic syndrome following shaft fractures of the leg: a significant late complication. *J Bone Joint Surg [Br]* 1987;69B:775-8.
6 Solonen KA. Prophylactic anticoagulant therapy in the treatment of lower limb fracture. *Acta Orthop Scand* 1963;33:329-36.
7 Berquist D, Efsing HO, Hallbrook T, Hedlund T. Thromboembolism after elective and post traumatic hip surgery—a controlled prophylactic trial with Dextran 70 and low dose heparin. *Acta Chir Scand* 1979;145:213-8.

Contraceptive services for ethnic minorities

Problems arise with contraceptive services for ethnic minorities because they are planned and provided by professionals from the ethnic majority, and the problems are caused not by the peculiarities of the ethnic minority but by the fact that the services are crossing cultures.

In an ideal world people would receive advice on contraception from a trained person of the same sex and racial background in a language they understood in an environment they found acceptable and non-threatening. Unfortunately much contraceptive advice for members of ethnic minorities in Britain is provided by doctors of a different culture from that of the patients. The doctors often do not speak the same language[1] and may have stereotyped views about the patients' cultures.[2-8] White doctors may also have little insight into the effects of racism on patients (and colleagues) from ethnic minorities. How can things be improved?

Authorities organising contraceptive services need to identify the communities that they are providing for and their special needs. They should know who makes the decisions on contraception and how they may best be contacted. The factors that influence the decisions on contraception are many and varied. Religious belief is often not as important as many think,[5,6] though it may dominate decisions for some people. It may also have effects in indirect and unexpected ways—for example, by emphasising the importance of sperm or attaching taboos to menstruation. Usually more important than religion, however, are people's experience and future plans, the influence of peer groups, economic factors, and media publicity.[5,6] Publicity about services must be in a form accessible to communities, and the written word—albeit in the right language—may often not be adequate.

Authorities must consider who provides the services. One aim should be to offer wide choices of advisers in terms of sex, race, and class, but staff should also be offered training in racism awareness, cross cultural consulting, and health and religious beliefs. Despite their widespread use, interpreters are often not helpful except in translating the doctor's instructions. Much better are patients' advocates.[7] These are trained members of ethnic minorities who both interpret the patients' needs and beliefs and provide an insight into the current beliefs of that community. They also interpret the needs of the medical community to the patient and are available for advice on health education and training of staff. All areas with large communities of ethnic minorities should consider employing advocates.

Finally, there are two points worth making. Firstly, improving contraceptive services for ethnic minorities will also improve services for the majority by improving skills in eliciting patients' beliefs and fears and in communicating and by leading to more flexible services. Secondly, it is no longer good enough for investigators to peer in on ethnic communities from the outside and make decisions about them. Information should come from workers who originate from the ethnic communities, so that decisions are made from within the community.[8]

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1 Shackman J. *The right to be understood*. Cambridge: National Extension College, 1984.
2 Helman C. *Culture health and illness*. London: Wright PSG, 1984.
3 Foster GM, Anderson BG. *Medical anthropology*. New York: Wiley, 1984.
4 Mares P, Henley A, Baxter C. *Health care in multiracial Britain*. Cambridge: National Extension College, 1985.
5 McAvoy BR, Raza R. Asian women: contraceptive knowledge, attitudes and usage. *Health Trends* (in press).
6 McAvoy BR, Raza R. Asian women: views on provision of contraceptive services and cervical cytology. *Health Trends* (in press).
7 Cornwell J, Gordon P. *An experiment in advocacy, the Hackney multiethnic women's project*. London: King's Fund Centre, 1984.
8 Burke A. Racism and psychological disturbance among West Indians in Britain. *Int J Soc Psychiatry* 1984;30:50-68.