1. What do you expect of your doctor/receptionist/patient?
2. What does the doctor/patient/receptionist expect of you?
3. Do the physical surroundings of the surgery matter?
4. What were your expectations from your doctor/practice and have these expectations changed?
5. How do you see the differences between National Health Service and private treatment?
6. How will you/a patient complain? How would you/the patient express this?
7. Are expectations different in the care of children?
8. What was your training? (doctor/receptionist)
9. How do you know if the patient is satisfied? (doctor/receptionist)
10. How do you see the role of doctor in the community?

The interview was recorded and later transcribed. The transcripts were then analysed. A total of 31 patients, 12 receptionists and 13 doctors were interviewed in four different group practices. To question 4 about expectations, there was a marked mismatch. Doctors and their receptionists thought that patients wanted to be cured and made better. Seventy per cent of all patients however, mentioned that they wanted to be listened to and taken seriously. It seems that patients were more interested in the process than the outcome. Interestingly, patients were right about what they thought doctors expected of them.

Receptionists tended to follow their doctor's views of patient expectations. However, no doctor had thought about what the receptionist expected of him; all the receptionists thought they wanted more support from the doctor. No patient thought that they had any responsibility to the receptionists, but receptionists expected patients to know the system and to abide by it.

There is other indirect evidence to suggest that patients think of the process of the medical encounter as equally or more important than the outcome. Klein in his book on patient complaints found that a high percentage of the complaints concerned the process of the medical encounter.[13] Recently a patient sued an obstetrician and won her case — she is reported to have said afterwards that she only sued because he did not say he was sorry.

We believe that as part of the quality initiative each practice should discover for itself (preferably using outside help) what its patients and staff expect. It may also be important to explain to patients what staff and doctors expect of them.

Such an exercise has educational benefit — it will also benefit patient care and satisfaction should be improved to the benefit of all.

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Monitoring of chronic disease

Sir,
In his address to the College Spring Meeting in 1985, the then Chairman, Donald Irvine, rightly stressed the importance of the general practitioner's role in chronic disease. Diseases such as hypertension, diabetes, asthma and rheumatoid arthritis provide a large part of this workload. In monitoring these conditions I have found the need for a flow chart. Previously drug companies used to supply cards for hypertension, which I adapted for use in other diseases. However, this source has now ceased, and I have designed a universal flow chart, which Duphar Laboratories Ltd kindly printed for me. The front gives patient details and lists some investigations which are particularly useful in hypertension and diabetes. The reverse side (Figure 1) is the real flow chart, and should provide parameters to measure and record in all the chronic diseases mentioned. It can be adapted for other measurements such as blood urea and thyroid functions.

The card has been in use in my practice for the past six months, and few snags have arisen. The weight scale in stones does not show small differences very clearly, but by using kilograms these differences can be enlarged.

I wish to encourage other practices to use these cards which are intended for Lloyd George envelopes, although no doubt larger A4 sheets could be designed. They extract information which gets lost in the narrative of the continuation cards, as well as giving a much clearer picture of changes in the important measurements in chronic disease.

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SYMBOLS:
Peak Flow: O - Blood Pressure: □ - Weight: △
Haemoglobin: * - E.S.R.: V - Other •
600/30 (0) 15 (0)
14 (0)
13 (0)
500/25 (0) 12 (0)
11 (0)
400/20 (0) 10 (0)
9 (0)
8 (0)
300/15 (0) 7 (0)
6 (0)
200/10 (0) 5 (0)
4 (0)
3 (0)
100/5 (0) 2 (0)
1 (0)
0 0
DATE

Figure 1. *Reverse side of universal flow chart.*

Characteristics of medical students wanting to become general practitioners

Sir,
We wish to present some data on the characteristics of medical students seeking a career in general practice compared with those opting for other specialties.

As part of a study into the development of student attitudes towards a career in psychiatry,[1] 498 students in six medical schools completed a questionnaire which included questions on respondents' sex,

political view (right wing, middle of the road or left wing) and medical philosophy — the last being a contrast between a technological, science-based approach to medicine and a humanistic approach stressing personal and social factors (this was measured by four Likert-type items).

All students in their first- and final-clinical years received a questionnaire early in 1981 — 40% returned them. Of those who responded 52% were in their first clinical year and 64% were male. Overall, 30% of the students regarded themselves as right wing, 45% as middle of the road and 22% as left wing (3% did not reply).

Table 1 summarizes the characteristics of the sample by specialty of first choice. The distribution of specialties varies significantly between first- and final-year students, the main change being that the proportion of 'undecided' students falls from 46% to 20%. The most dramatic increase in popularity is for general practice; surgery and psychiatry show a reduction in popularity.

Political view, medical philosophy and sex also vary between specialties. All these differences are significant at $P < 0.001$, using the chi-square test for categorical data and analysis of variance for ordinal scales.

Political view. Surgery and pathology are favoured by right wingers — seven out of every 10 would-be surgeons classified their own views as right wing. Psychiatry and obstetrics and gynaecology attract students who are furthest to the political left, with only 16% of right wingers. General practice and the other specialties attract those students who are more middle of the road.

Medical philosophy. Some specialties attract students with a more technological approach — predictably perhaps surgery and pathology and maybe less predictably paediatrics. A more humanistic approach is favoured by those who opt for psychiatry, obstetrics and gynaecology and general practice.

Sex. The overall proportion of men in the study is 64%, but the percentage of men opting for each specialty varies widely. The most popular specialties with men are orthopaedics, surgery and general medicine; women tend to select paediatrics, obstetrics and gynaecology, general practice and pathology.

Several of the variables associated with choice of specialty are themselves correlated with each other (for example, political view and medical philosophy) which gives rise to the possibility that controlling for some variables may eliminate the effect of others. This was examined by further multivariate analysis. It was found that though partially linked, political views, medical philosophy and sex are individually and substantially related to vocational preference. The potential implications of this to the selection of medical students are intriguing.

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Table 1. Characteristics of students by specialty of first choice.

Specialty of first choice	Total number of students selecting specialty as first choice	Ratio of final year to first year students	Percentage of total sample	Percentage of women in the sample	Mean score for political view[a] (range 1–3)	Mean score for medical philosophy[b] (range 4–20)
General practice	111	2.82:1	*22*	*51*	1.9	9.1
General medicine	78	1.34:1	*16*	*18*	1.8	10.3
General surgery	33	0.71:1	*7*	*18*	1.4	11.5
Obstetrics and gynaecology	17	1.56:1	*3*	*53*	2.2	8.1
Orthopaedics	9	1.37:1	*2*	*11*	1.8	9.7
Pathology	6	2.18:1	*1*	*50*	1.5	12.5
Paediatrics	33	1.03:1	*7*	*55*	2.1	10.9
Psychiatry	14	0.82:1	*3*	*29*	2.2	8.1
Other	29	0.89:1	*6*	*28*	2.1	9.2
Undecided	168	0.43:1	*33*	*35*	2.0	9.8

[a]High score = left wing, low score = right wing. [b]High score = technological approach, low score = humanistic approach.

Specialist qualifications

Sir,

General practice is now an established specialty and no longer looked on as the home of those doctors who are failed specialists. It has its own training, its own College, and its own specialist qualifications. General practitioners are now as well qualified in their own specialty as are hospital specialists in theirs.

In consequence I feel that the time has come to recommend that general practitioners use their additional qualifications more freely than they do at the moment, appending them after their names in letters written to their hospital colleagues and to other doctors or addressees where the specialist qualification in general practice is pertinent to the subject under correspondence. It is, after all, logical for a general practitioner to write a referral letter to his medical colleague giving his specialist qualifications in the same manner that the medical colleague will reply to him with MRCP or a similar qualification appended to his own name in order to demonstrate his own expertise.

I know that a number of general practitioners do append their specialist qualifications and indeed my own practice use this style in their referral letters. I hope I can persuade more of my colleagues to do the same, and so increase the dignity of our specialty.

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Part-time posts in general practice

Sir,

I am a vocationally trained general practitioner looking for a permanent post. I am also single and female. I recently applied for a part-time post and understand that I was not considered for interview because of an instruction from the local medical committee that women without family commitments will not be considered for such posts.

My concern and anger at this revelation is twofold. First, I am only too aware how difficult it is for women to gain a full-time partnership in general practice, and had reconciled myself to part-time general practice with limited commitment to another branch of medicine. I now discover this is not possible. Secondly, it seems regrettable that practices will not take up the opportunity to interview likely candidates because of a discriminatory ruling by the local medical committee.

Rarely have I felt moved to put pen to paper on such matters, but on this occasion I felt it was necessary.

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