hands; the latter joints were stiff. He also developed a faint macular rash on his forearms for about 48 hours. The whole illness lasted for nine days.

The patient's wife had had a fleeting rash on her hands, forearms and the tops of her legs a fortnight previously, lasting about 24 hours only. However she had no malaise or joint symptoms. About a fortnight after my patient's illness, his 10-year-old daughter developed a rubelliform rash all over her body which lasted for 10 days. She also had no malaise or joint symptoms. This man's past history consisted of a nasal allergy treated by desensitization injections, two episodes of neck pain eight years previously with evidence of mild cervical spondylosis on the X-rays and an episode of pain in both knees two years previously after unaccustomed jogging on roads. The knee symptoms had settled rapidly and the erythrocyte sedimentation rate at the time was 3 mm h \(^{-1}\) with a normal uric acid level. His family history consisted of a mother with widespread arthritis, the exact nature of which was not known. She had been severely affected from her mid-30s onwards and had had bilateral knee replacements.

The patient's full blood count was normal apart from an eosinophilia related to his nasal allergy. The erythrocyte sedimentation rate was 17 mm h \(^{-1}\) and both the infectious mononucleosis screening test and RA latex test were negative. Uric acid level and antistreptolysin 0 titre were normal. Paired sera showed no difference in rubella haemagglutination inhibition titres (both 1:32). However, a radioimmunoassay performed at the Virus Reference Laboratory, Colindale, showed that anti-human parvovirus immunoglobulin M fell from over 100 units to 66 units over a period of 10 days, indicating recent infection.

Contrary to Dr Everett's statement, the clinical picture of adult parvovirus infection has been described.\(^1\)\(^2\) It is interesting that my case was in a man, as arthralgia is far more common in women. It seems that not all patients have joint symptoms which are so mild or which settle so quickly; occasionally patients may be so badly affected that they present at rheumatology clinics. In a group of 19 such women, although joint symptoms were improved within two weeks, all but two patients experienced symptoms which persisted for more than two months and in three cases for more than four years.\(^1\)\(^2\) On rare occasions patients have arthritis which is severe enough to warrant hospital admission.

It appears that my patient had joints which were vulnerable to this particular viral infection. However it seems unlikely that he is developing anything resembling his mother's arthritis.

SAM ROWLANDS

35-37 The Baulk
Biggleswade
Bedfordshire SG18 0PX

References

Patients' access to their records

Sir,

In a pilot study carried out in 1984 at a Birmingham practice a random sample of patients were asked their initial responses to reading their records.\(^1\) The practice in which the study was undertaken is situated in an inner-city area of Birmingham and has 4000 patients of diverse cultural backgrounds.

A small number of patients are not given access to their records. Information that is potentially distressing is communicated personally by the doctor to the patient before the patient is given the record. A record is not shown to a patient if it contains information given by a third party on the understanding that it will not be shown to the patient, if the patient asks not to be handed the record, (perhaps because the patient's spouse insists on looking it), or when a patient is so disturbed that any information in the record is likely to be misinterpreted.

The practice uses F5/F6 envelopes for records and allows patients access to their complete record. Patients are given their record by the receptionist when they come to the surgery. They are invited to read their notes in the waiting room and can do so before seeing the practitioner or after the consultation.

Over a period of 10 days 100 patients aged 16 years and over were randomly selected in ordinary surgery sessions and were invited to complete a questionnaire. Only three patients did not do so.

Of the 97 patients who completed the questionnaire 85 said patients should have the right to see their records. Of the 60 patients who had read their records 51 said they could understand about half or more than half, 48 said it made understanding their problem easier, 37 said it helped them in making decisions, and 45 said it increased their satisfaction with treatment.

Conclusions cannot be drawn from this small pilot study. The results, however, show that a majority of patients in the sample welcomed the chance to read their records and did so when given the opportunity. Patients' access to their records is not simply to be viewed as an abstract issue of rights — members of the primary health care team involved in the study believe that allowing patients to share and read their records has therapeutic benefits.\(^2\) The experience of the practice is that the advantages far outweigh any disadvantages and that difficulties can be overcome.

MARY GITTENS

Oaklands
Bagninswood
Cleobury Mortimer
Kidderminster
Worcs DY14 8NA

References

Referrals from general practice to specialists in Denmark

Sir,

It is well known that there are unexplained differences in the rates at which general practitioners make referrals to other medical specialists.\(^1\)\(^2\) One of the most important aspects of primary care is the general practitioner's need for advice. We investigated data from a study carried out by the Danish National Health Service in Ringkjøbing County\(^3\) on 17 586 referrals from 141 general practitioners to specialists in seven specialties — dermatology, internal medicine, general surgery, obstetrics-gynaecology, orthopaedics, ear-nose-throat and physiotherapy. In Denmark there is a permanent relationship between the patient and general practitioner and it is compulsory for a patient to be referred from general practice for consultation with a specialist. As an expression of the referral rate a referral index was estimated for every general practitioner. The referral index is the number of referrals to the specialists in the seven specialties per 1500 patients per year including children, standardized by age and sex to an average practice in Ringkjøbing County. The
background population was 246,468 patients.

The median of the referral index was 119 referrals per 1500 patients per year. The following variables were evaluated in relation to the referral index: distance from the specialist, practice size, practice type, years of experience in general practice, practice activity (number of consultations per 1500 patients per year standardized by age and sex), workload (number of consultations per general practitioner per year) and working agreement (estimated by the number of supplementary expenses — payment for special diagnostic investigations and treatment by the general practitioner).

The general practitioners were ranked in three equal groups; for practice type they were ranked in only two groups (single-handed and partnership). The Kruskall Wallis test was used to determine the statistical significance of the differences between the referral index of the groups. To make an analysis of possible covariation between the variables, we cross tabulated and used the chi-square test. If covariation between two variables was found we stratified in order to analyse the influence of the variable on the referral index.

The main results of the investigation were: general practitioners who were a short distance from the specialist had a significantly higher referral index than the other two groups. General practitioners in single-handed practices had a higher referral index than their colleagues in partnership practices, but the result was not statistically significant. General practitioners with numerous supplementary expenses had a significantly lower referral index than their colleagues. There was no relationship between the referral index and the following variables: practice size, years of experience in general practice, practice activity and workload.

Five conclusions can be drawn from the results of our investigation. First, the general practitioners adjust their work according to the ease of referral to specialists. Secondly, general practitioners with a large list and/or a heavy work load do not reduce this by more referrals to specialists. Thirdly, comprehensive diagnostic tests and treatment (a high number of supplementary expenses) in general practice reduce the number of referrals to specialists. Fourthly, considerable experience in general practice does not reduce the referral rate. Finally, the Danish National Health Service is well organized for the quantitative investigation of general practitioners' referrals to specialists.

HENRIK TOFT SORENSEN
BO CHRISTENSEN

Institute of General Practice
University of Aarhus
Finansgade 10
8000 Aarhus C
Denmark

References

Buon Natale

My mother died on Christmas day, after nearly two years fighting against mammary carcinoma. Both my parents lived in Italy, my mother being a bilingual Italian. From the very beginning she sought the opinion of several experts all of whom advised a mastectomy, although she was 65 years old at the time and there was good reason to believe that the disease was beyond what we in Britain would consider an operable stage.

Once the mastectomy was done, several different experts were consulted again and each gave conflicting advice. As there are no general practitioners in Italy she was followed up by the surgeon who did the original operation, a physician with an interest in chemotherapy and a radiotherapist. In the following 18 months she underwent several minor surgical interventions to remove cutaneous spreads, three very strong radiotherapy courses and four equally strong cycles of chemotherapy. The results were such that looking at her one did not know whether the disease or the treatment were worse. Throughout this ordeal she was convinced that all this was going to lead to a cure, as no doctor seemed ready to tell her the truth when asked. No amount of caution expressed by either my wife or myself was able to slow down her quest for a cure. The end when it came was worse than expected. We arrived from Britain to find her in a bed in a private room in a district general hospital in a town in Tuscany. Her ureters had been compressed by enlarged lymph nodes and the resulting blockage had been partly relieved by direct catheterization of one of them. Her general appearance of bloatedness contrasted with her emaciated face which told us that the end was near.

The hospital staff only came once a day to wash her in the morning, but her mouth which was terribly dry was never wetted nor was it cleaned. Medicines were handed out, often large capsules which were hard to swallow for somebody who had trouble in swallowing even orange juice. Every morning blood tests were done (I never did find out why) and she was given a short burst of intravenous fluids 'to keep her hydrated'. This meant quite a laborious search for new viable veins each morning thus increasing her suffering. No regular pain-killing drugs had been prescribed and there seemed to be a reluctance from both doctors and nurses to speak to her, comfort her or even touch her. Religious comfort was also sadly lacking in compassion, the last rites were given in a hurried slovenly fashion by a friar who refused to believe me when I told him she was dying.

We tried as best as we could to comfort her and to relieve her of some of her discomfort. What she must have suffered I can only guess at. The effect all this had on us was devastating and only time will heal, I hope, the wounds left by it. Well versed in the theory of bereavement I found myself confronted with the double feeling of loss and guilt for not having been able to do more for her. This I find much more difficult to cope with than loss. Loss in these circumstances is inevitable, and my training helps to rationalize it and its causes. Guilt at the way she suffered is tempered by anger felt towards the people my mother was entrusted to and who failed her in her time of need.

The experience of my mother's death left me in no doubt that of all the skills required by the doctor in general and the general practitioner in particular compassion is the greatest — compassion towards a fellow human being, towards a patient, towards a person who is ill and towards the sick person's feelings and those of the family. This is what makes medicine different from other sciences and indeed what elevates general practice to an art.

T.O. JEFFERSON

3 Sunbury Close
Bordon
Hants GU35 0BW