

to upset the frightened with infective ear-ache by examining the ear against their will. Is it good scientific practice only to befriend and prescribe antibiotic on that particular occasion, so that future consultations are characterised by friendship, and co-operation, with subsequently higher standards?

This concept of foregoing immediate scientific satisfaction in favour of a future high-standard 'atmosphere' is illustrated again by the recently-registered, neurotic, elderly patient. Such a patient arrives from her previous doctor with a string of medications upon which she (or he) is allegedly dependent. A wise (and scientific) doctor will refrain from changing the drugs until such a time as rapport has been achieved. This may mean prescribing a host of slimming tablets, sleeping tablets, nerve tablets and tonics until a working relationship has been established.

Of course, friendliness, toys, business-like efficiency, and helpful consultants and hospitals all go toward the establishment of confidence and trust by the patient in their family doctor. But should we avoid rectal and vaginal examinations for such reasons? To what extent do we give in to patients' pressures and wishes, and to what extent is it in their present or ultimate interests?

I should like to know what techniques are employed by doctors to achieve long-term scientific satisfaction, and to what extent the short-term diagnostic and therapeutic measures are thereby compromised.

D. M. SMITH

67 Greenhouse Farm Road,  
Runcorn,  
Cheshire, WA7 6PR.

#### REFERENCE

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#### FALSE URINARY INFECTIONS FROM DIP-SLIDE CULTURES

Sir,

During 1975 in our laboratory there was an apparent increase in the percentage of antenatal urinary infections (bacteriuria  $\geq 50,000$  organisms/ml) due to gram-positive organisms; this rose from 22 per cent of 164 infected urines in 1974 to 42 per cent of 253 in 1975. The most frequent gram-positive organism isolated was *Staphylococcus albus*: from 11 per cent of apparent urinary infections in 1974 and 26 per cent in 1975. *Micrococcus Subgroup 3*, a recognised urinary pathogen, was separately identified from a further three per cent of infections in 1975.

The apparent increase in number of *Staph. albus* infections coincided with an increased use of dip-slide cultures. Since this organism is a commensal of the normal urethra, we suspected that these dip-slide cultures had been taken from early-stream urines instead of mid-stream urines. Therefore, when a significant bacteriuria

was found, a repeat dip-slide culture was requested, the importance of the use of mid-stream urine for the dip-slide sample being emphasised.

Of 31 women whose first dip-slide showed significant *Staph. albus* bacteriuria, 28 had sterile urine or insignificant *Staph. albus* bacteriuria in the second dip-slide. Information concerning treatment of the infection with antibiotics was available for only 14 of these 28; ten of the 14 had received no antibiotic therapy and all ten showed sterile second urine specimens; two women had inappropriate therapy (nalidixic acid to which the *Staph. albus* was resistant) and their repeat dip-slides were also sterile; the remaining two women had sterile urine after appropriate antibiotic therapy.

These findings suggest that some so-called urinary infections due to *Staph. albus* are in fact due to skin or urethral contamination. This emphasises the importance of instructing nursing staff and patients in the necessity of holding the dip-slide in mid stream urine.

ELIZABETH D. S. MURRAY

Microbiology Laboratory,  
Ayrshire Central Hospital,  
Irvine.

#### MATHEMATICAL MODELS OF GENERAL PRACTICE

Sir,

I agree with Dr Russell that the negative binomial provides a better fit to the distribution of episodes in general practice. I discovered this when I attempted to apply the geometric distribution to the episode frequencies recorded by separate practices. This work will be described in a paper to be printed in the *Journal of the Royal Statistical Society-C (Applied Statistics)*. Dr Crombie has, however, pointed out to me that there are certain practices in which even the negative binomial does not fit the distribution of episodes. The reasons for this are unclear at this time.

S. JAMES KILPATRICK  
Chairman and Professor

Department of Biostatistics,  
Virginia Commonwealth University,  
MCV Station,  
Richmond,  
Virginia, U.S.A.

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- Crombie, D. (1976). Personal communication.  
Kilpatrick, S. James (1976). *Journal of the Royal Statistical Society-C*. In press.  
Russell, I. T. (1976). *Journal of the Royal College of General Practitioners*, **26**, 357-58.

#### WHAT KIND OF PRACTICE

Sir,

I am concerned, as a recent recruit to general practice, that despite the enormous strides the