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.

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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 antibotics was available for only 14 of these 28; ten of the 14 had received no antibotic 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

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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

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WHAT KIND OF PRACTICE

Sir,

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

College has made in improving standards, its activities are becoming more and more divorced from what general practitioners are doing every day in their surgeries.

The present emphasis on educational theory and communication, with Nuffield courses and Balint seminars, seem to me an irrelevance when many practising doctors do not have adequate facilities for examining patients, and routinely prescribe antibiotics for all fevers.

There is a danger in devoting too much time to the complexities of the doctor-patient relationship, and not enough to straightforward diagnosis and management. Even the most rudimentary research into evaluating what we do cannot start until doctors are in agreement about criteria for diagnosis, and until they keep adequate notes. Our ignorance about what constitutes minimal criteria for diagnosing simple conditions such as otitis media and bronchitis, and the discrepancies which exist between doctors in their management, is an example of how little we know about common ailments.

It must be the first job of any body representing general practice in this country to ensure that not only a good example is set, but that bad practice is recognised and condemned. . .

As a starting point, we must define to our own satisfaction what we mean by certain diagnoses, consider the groups most at risk, and concentrate our resources there. In this way we improve the overall standard of medical care. Only when this is done will the general practitioner assume the status of a specialist and get the recognition he deserves.

PETER WILLIAMS

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Sir,

I have just received yet another letter about money from the College. I have studied the accounts in the *Annual Report* and I simply cannot see why the College has got into such debt. But having got into a mess, surely it would be better to think in terms of economies rather than to ask ordinary members for more money? What guarantee have we that there will be any end to it? In every area of life at the moment inflation is used as an excuse for demanding more and more and more. It is just this attitude that causes inflation.

Economies which spring readily to mind are:

(1) We can do without the excessively grand quality of the College stationery.

(2) Almost every article in the *Journal* would benefit from being cut in length; you could then publish it quarterly.

(3) Many of the travelling fellowships produce results of minimal value, many could just as easily and more cheaply be obtained by commissioning an article from abroad.

(4) Much of the research is repetitive and boring: far more stringent criteria should be used before our money is given to doubtful projects.

(5) I love the building at Princes Gate. It really is a joy to walk through it; but how many members get how much joy from it? Surely it would be more realistic to move to more modest accommodation?

If the College still insists on wanting more money from us—what do you think ordinary members are getting for their subscription? The *Journal* really is not worth it. As I understand it, the aim of the College is to upgrade primary care in Britain. But what has it actually achieved? Young doctors now have the option of joining schemes, but many of them are undersubscribed. Some of the best primary care physicians have hidden themselves away from patients in professorial departments. We still have trainees used as cheap labour, and worst of all we still have ancient members of the profession making no attempt to keep up to date. It is a regular occurrence to attend a postgraduate lecture and watch the general practitioners stay awake long enough to sign the forms to get more money and then drown the (often distinguished and busy) lecturer with their snores.

Priorities should be for compulsory, continuous audit for all doctors, members or not, and a basic examination at the age of 65.

I shall not join the variable direct debit scheme and I shall decide in July whether to remain a member.

EVELYN ADEY

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London, N.W.1.

The total cost of the *Journal* to the College for the year ending 31 March 1976 was £4·03p per member/associate.—*Ed.*

THE M.R.C.G.P. EXAMINATION

Sir,

I enjoyed reading Professor Wilkes' article (March *Journal*). It is a pity that he did not enter under a pseudonym (and I would have been pleased to suggest one), and take the orals under a disguise (if, indeed, that were possible). But he has failed to convince me that I should take the examination. Now that he has passed, will he answer the following questions?

(1) What is the evidence that those who pass the examination are better general practitioners than those who fail or who do not take it at all?

(2) What does the examination test? Does it determine whether the doctor will always treat others as he would like to be treated himself? Does it determine whether he is careful and thorough in his history taking, examination and note-keeping? Whether he knows when he does not know, and knows when to seek advice? Whether he will prescribe drugs as a substitute for giving time to talk to the patient? Whether he will ever refuse to see or visit a patient in need? These qualities and others may be thought to be