The management of vaginal discharge in general practice*

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SUMMARY. A group of general practitioners in active practice were asked to report how they preferred to manage the symptoms of vaginal discharge presented by a woman in her twenties. Subsequently the same practitioners reported their management of such patients in their practice.

A shortfall was found for all practitioners between their declared intention and their actual practice.

This method of analysis offers a way of working towards a consensus in clinical care and also of auditing medical performance in general practice.

Introduction

GENERAL practitioners are often confronted by patients with the single symptom, vaginal discharge, presented by a woman in her twenties. This study sought to discover how general practitioners responded to this symptom and to create a consensus view of what should be done. The method derives from that used by Curtis (1975) in auditing treatment with digoxin.

Method

Two sets of forms were designed. The first asked the doctor to describe aspects of the patient's history (Table 1), examination, and investigations which he regarded as important. He was asked to assess these points into categories according to his frequency of seeking them. Thus he might always (that is, more often than 95 per cent) enquire how long the symptom had been present, usually (that is, 65 to 95 per cent of times) enquire about the colour of the discharge, or seldom (that is, 5 to 34 per cent of times) ask the date of last menstruation. Each column was scored (5 for 'always' down to 1 for 'never') and so it was possible to give each question a score from which a ranked consensus could be constructed.

After some months a second form (Table 2) was sent out to those doctors who had completed the first and shown willingness to continue. This asked for details of history, examination, and investigation of 10 cases where women in their twenties presented with vaginal discharge. This form also included a column for constraints in which doctors might record factors which prevented them from doing all they wished.

Doctors were selected in three ways: the largest group consisted of friends approached personally; the second group were volunteers responding to a letter sent to all doctors on the list of two family practitioner committees in the West Midlands, and a third group consisted of a small number of research workers interested in the subject all over the British Isles. Perhaps not surprisingly, response to the second form was greatest in the first group, poor in the second, and virtually non-existent in the third. Any form of audit is still a threat and returns are best when the doctors know each other.

Results

Forty-six doctors completed the first form from which a consensus of important points in the history was constructed (Table 3). Thirteen questions had an average score of greater than one but only questions relating to irritation, oral contraception, duration, and colour received consistently high ratings. Tables 4 and 5 show the figures for examination and investigation. A pattern emerges of a brief history of a few specific questions followed by speculum, bimanual and vulval examination, a high vaginal swab, and sometimes a cervical smear. Many other items of information were sought but were uncommon.

After the return of the second form, which was sent out some months after the first, it was possible to compare actual performance with intended performance. Of the 46 original doctors, 28 returned fully completed

*Based on a paper presented at the Spring General Meeting of the Royal College of General Practitioners in April 1978.

Table 1. Frequency of questions intended by general practitioners when taking a history for vaginal discharge.

Examination	Always >95 per cent	Usually 95 to 65 per cent	Often 64 to 35 per cent	Seldom 43 to 5 per cent	Never <5 per cent
1. How long have you had it?	✓				
2. Are you on the Pill?	✓				
3. Does it itch?		✓			
4. What colour is it?		✓			
5. Any urinary symptoms?			✓		
6. When was your last period?				✓	
7.					
8.					
9.					
10.					

Table 2. Follow-up form sent to participating doctors.

History		
1. How long?	6. Last menstrual period?	
2. On Pill?	7.	
3. Colour?	8.	
4. Offensive?	9.	
5. Husband's symptoms?	10.	
Examination		
1. Speculum	6.	
2. Vaginal examination	7.	
3.	8.	
4.	9.	
5.	10.	
Investigation		
1. None	6.	
2.	7.	
3.	8.	
4.	9.	
5.	10.	
Constraints		
Friday evening—laboratory closed		

Table 3. History.

	Total score	Average score (Number = 46)
Most commonly asked questions relating to:		
Irritation	162	3.5
Oral contraception	155	3.4
Duration	150	3.3
Colour	149	3.2
Consort's symptoms	76	1.7
Had It before?	75	1.6
Urinary symptoms	72	1.6
Offensive	71	1.5
Menstrual history	70	1.5
Consistency	60	1.3
Sexual history	58	1.3
Last menstrual period (pregnant?)	56	1.2
Bleeding	49	1.1

Questions averaging less than 1.0 have been excluded.

second forms. The comparison between predicted and actual performance is shown in Table 6. Some of the differences must be due to failure of recording; for example, vulval inspection scores only 1.1 but speculum examination scores 3.3, and it is difficult to pass a speculum without inspecting the vulva. Other reasons for failure to reach the theoretical standard may be found among the constraints (Table 7) but since these occurred in only a third of cases they cannot explain all the shortfall.

Examination of one particular doctor's performance helps to illustrate how the group performed. This doctor enjoys a reputation for excellence as a general practitioner and his results are typical of the group as a whole (Table 8). In assessing his shortfall two systems of marking have been used. In the first any actual score less than the predicted score is regarded as shortfall; in

Table 4. Examination.

	Total score	Average score (Number = 46)
Commonest methods of examination:		
Speculum	158	3.4
Bimanual	135	2.9
Vulval inspection	135	2.9
Abdomen	51	1.1

Table 5. Investigation.

	Total score	Average score (Number = 46)
Commonest investigations:		
High vaginal swab	139	3.0
Cervical smear	107	2.3
Urine sugar	67	1.5

Average scores of less than 1.0 have been excluded.

Table 6. Results from second questionnaire.

	Average predicted score	Average actual score
History		
Irritation	3.5	3.0
Oral contraception	3.4	2.4
Duration	3.3	2.6
Colour	3.2	2.4
Consort's symptoms	1.7	1.3
Had it before?	1.6	1.2
Urinary symptoms	1.6	0.8
Offensive	1.5	0.8
Menstrual history	1.5	0.6
Consistency	1.3	0.2
Sexual history	1.3	0.5
Last menstrual period (pregnant?)	1.2	0.8
Bleeding	1.1	0.5
Examination		
Speculum	3.4	3.3
Bimanual	2.9	2.1
Vulval inspection	2.9	1.1
Abdomen	1.1	0.6
Investigation		
High vaginal swab	3.0	2.6
Cervical smear	2.3	0.5
Urine sugar	1.5	0.3

Forty-six doctors took part in the first questionnaire, and 28 completed the second questionnaire.

Table 7. Constraints reported.

None	181 (67 per cent)
Physical (menstrual, tenderness, hymen)	17
Psychological (embarrassment)	7
Social (patient a nurse)	5
Organizational:	
laboratory closed	21
other	13
Third party (student, no chaperone, angry husband)	10
All other	21
Total	275

Some patients had more than one constraint.

the second, easier scoring, if the actual score is only one group below the predicted score (that is, he predicted 'always' and performed 'usually' in Table 1) then this is not regarded as shortfall. This doctor has a shortfall of 12/16 or 11/16 according to strict or easy marking. Some of his shortfall might be explained by the constraints but these refer to investigation and could not have produced improvement. As has been pointed out there may well be a reporting error in vulval inspection and possible abdominal examination. The fact remains that this excellent general practitioner has a large discrepancy between what he says he does and what he actually does. When we look at the shortfall for the group (Table 9) we can see that this doctor's performance is in no way atypical.

Discussion

This study illustrates a great discrepancy between what doctors believe they do and what they actually do. This difference, which I have named the paranoia factor, is one of the major barriers to the introduction of audit. It is interesting that the one doctor who came nearest to reaching his predicted standards was very modest in setting them. This confirms the suspicion that any group

Table 8. One doctor's results.

	Predicted	Actual	Shortfall	
	Per cent	Per cent	Hard marking	Easy marking
History				
Duration	*>95*	*60*	x	x
On Pill	*>95*	*70*	x	✓
Had it before?	*65-95*	*20*	x	x
Colour	*65-95*	*90*	✓	✓
Consistency	*65-95*	*10*	x	x
Urinary symptoms	*35-64*	*80*	✓	✓
Menstrual history	*5-34*	*0*	x	x
VD	*5-34*	*10*	✓	✓
Psychological problems	*5-34*	*0*	x	x
Examination				
Vulval inspection	*>95*	*0*	x	x
Speculum	*>95*	*10*	x	x
Bimanual	*>95*	*50*	x	x
Abdomen	*65-95*	*0*	x	x
Investigation				
High vaginal swab	*35-64*	*60*	✓	✓
Mid-stream urine	*35-64*	*0*	x	x
Referral	*5-35*	*0*	x	x
Shortfall			**12/16**	**11/16**
Constraints				
Laboratory closed	1			
Swab taken before	1			
None	8			

Table 9. Shortfall of group.

28 doctors completed the second form		
All showed a shortfall		
Range 1/11 to 18/19		
Total shortfall:		
336/465 (strict criteria)	*72* per cent	*The paranoia factor*
232/465 (easy criteria)	*50* per cent	

starting out to audit its behaviour must start with very low standards for if it fails to realize the first standards it sets it is likely to dissolve in disillusion. Once first standards are met these can slowly be pushed higher, rather like the bar of a high jump.

The question which emerges from the study, however, is why there should be a paranoia factor. Perhaps it is that we are all bad doctors—not a view likely to be held by anyone knowing the particular group of general practitioners taking part in this study.

An alternative is that we have been inappropriately taught and on entering general practice have had to relearn how to cope with the mass of symptoms presented. Somehow old teaching, backed by the force of personality of the professors of our medical schools, lurks in our minds as the 'right' way even though our general-practice pragmatism has long proved this to be wrong. In fact both are probably partly true: no doctor is so good he cannot be better, and this also applies to teachers.

Reference

Curtis, P. (1975). *British Medical Journal*, 4, 747-749.

Acknowledgements

My thanks are due to all those doctors who took part in this survey and to Sir John Stallworthy, Professor Peter Curzen, and Dr H. J. Wright who offered advice and criticism on this paper.

Transcription errors in the drug information supplied from hospital to general practitioners

When attempts are made to copy the same information onto several independent documents, transcribing errors are virtually inevitable; yet this frequently occurs when a patient is discharged from hospital. We have studied the prevalence of transcription errors among 56 acute medical patients by comparing the drugs listed in their pharmacy scripts, discharge notes, and discharge letters. The information failed to match in 16 per cent of patients when pharmacy scripts were compared with discharge notes, in 39 per cent when comparing discharge notes and discharge letters, and in 43 per cent when pharmacy scripts and discharge letters were compared. General practitioners were therefore misinformed about the drugs dispensed at discharge to nearly half their patients.

Reference

Wilkin, T. J., Dodd, W., Christopher, L. J. & Crooks, J. (1978). *Health Bulletin*, **36**, 13-16.