Time and the General Practitioner

Sir,

The interesting article by Hull and Hull (February *Journal,* p.71) reminds me of a project which my own indolence allowed me to neglect during 38 years in practice in Bushey. This was to test the hypothesis that patient satisfaction would correlate with that patient's perception of the nature of the consultation as unhurried. One would need the following facts about sufficient consultations (to allow fair conclusions even if not full statistical significance): the actual time taken by the consultation (recorded by doctor or receptionist), the time that the patient estimated for that consultation and a measure of the satisfaction of the patient with that consultation.

My guess would be that if the patient felt that the consultation lasted less than the actual time, then satisfaction would be on the low side, conversely if the patient overestimated the time of the consultation, then satisfation is likely to be high. If the hypothesis proved to be correct, then general practitioners might like to develop strategies which would remove any sense of 'hurry' from the consultation, and to stress methods (I almost said manoeuvres) which give a sense of 'space' for the transaction.

As a small criticism of the article, is it not a little naughty (Figure 1, question 3) to have four degrees of dissatisfaction with the time taken, and only one (or is it two?) of satisfaction? Nevertheless a good, thought-provoking study; will some of my colleagues take up this further challenge?

D. G. WILSON

9 Banhams Close
Cambridge CB4 1HX.

Sir,

I read with interest the paper by Hull and Hull (February *Journal,* p.71). I really wonder whether the statement in the results section that 'most patients (91 per cent) felt that the time their doctor gave them was just about right' is compatible with the conclusion that 'these findings support the view that patients are dissatisfied with the time given to them.'

The arguments given to support this conclusion are somewhat tenuous, proceeding from the finding that a relatively small number of patients felt that they were unable to tell their doctor about their problems and slightly more of these were in the group whose appointments were of shorter duration. Would it therefore not be more helpful to look at other reasons for poor communication rather than increase the appointment time of the 90 per cent of patients who felt that they were able to communicate their problems to the doctor either very well or fairly well?

J. P. VALENTINE

St Chad's Surgery
Midsomer Norton
Bath BA3 2HG.

Medical Records

Sir,

Summary cards and the enclosures in some sort of chronological order—this is the criterion which is drummed into training practices as the essential for good practice records. Yet how often do incoming notes for new patients rise to these heights? We did a survey of 100 folders coming to us from the FPC and found 11 per cent had summary cards and, with the most lenient interpretation possible, 40 per cent were in some sort of order. For 30 patients coming from training practices the figures were a little better (20 per cent and 53 per cent), which all goes to show the abysmal state of general practice records at the present time.

CHRISTOPHER ELLIOTT-BINNS

31 Church Street
Cogenhoe
Northampton.

Why not do it Yourself?

More and more articles in the medical press now stress the importance of screening, and in particular how it can be cost effective if done in their special way. More and more screening programmes seem to have as their objective 'I've done it!' when in fact they mean that they have employed someone else to do their work, and they have managed to claim the cost of employing someone else back, so they have spent very little in 'having done it'. It is rather like an age sex/register, it does not help the patient, unless it is used and used thoroughly.

We have an ABIES computer system, which has a vast flexibility for not only selecting patients who have a certain factor, but also can select out those patients who are 'unknown' for that factor. With the aid of this we have been performing cervical cytology, initially on those over 35, but now to all women over 25, as well as those of younger ages on our contraceptive list.

A recent article justified the expense of employing a nurse to screen the bloodpressure of all men over the age of 35, by asking her also to perform a cervical smear on women over the age of 35. A comment was made that 'no pathology was found as a result of the examination of the cervical smears . . .', but this whole programme was performed by the nurse, and not by someone whose training is towards recognizing disease as part of a person, and, in the case of a general practitioner, as part of a whole family. In our practice, of similar size to the screened practice, we have been performing routine cervical cytological examinations for the past eight years. Disease found and treated included: malignant ovarian cyst; anaemia due to fibroids; two carcinomas in situ; many monolial, trichomonal and actinomycetes infections; two malignant melanomas on the soles of the feet (we use the left lateral position); and one case of acute appendicitis. Not in the screening, but referred from the local family planning clinic for treatment of persistent inflammatory smears (three), was a woman with a fully developed carcinoma of the cervix, which needed only a speculum examination to diagnose it.

Although a nurse can be trained to take as good a smear as a doctor most of the above abnormalities would have gone unrecognized if the task had been delegated to a nurse. I find it impossible to equate the extra work for the doctor in the financial exercise, although most of the conditions found would eventually have taken up considerably more time if not found by the screening and treated. Would the author of the original article have found more abnormalities, and perhaps provided more effective health education, if a doctor had been performing the screening? Perhaps this could be a profitable line of research.

Yes, using a computer we have a marvellous opportunity to offer preventative medicine to all those people at risk; but we must use it, and be prepared to do the work ourselves.

M. WATSON

50 Buxton Road
Weymouth
Dorset DT4 9PN.

Career Structure for Deputizing Doctors

Sir,

I am not quite sure if members of the College fully realize that measures supposedly to control and improve deputizing as proposed by the Minister would in effect lead to the closure of most services—good and bad! I hardly think such a measure deserves the support of the College which acknowl-