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?

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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?

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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.

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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.

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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-

edges the rightful place of deputizing as an approved method of providing out-of-hours cover.

As a full-time deputy I fully accept the need to introduce measures to improve the present position. Certainly I would agree that all deputies should be fully trained general practitioners. I would also accept local control by an FPC sub-committee although I would dispute the proposed content of such a committee. Might I further suggest that compulsory independent audit and a proper salary and career structure for deputies should also be recommended.

Let us not deny that the present provision of out-of-hours cover needs much fuller debate. In the circumstances would it not be more reasonable to advise the Minister to await further discussion and in particular the report of the College's proposed working party on out-of-hours cover?

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Full-time deputy

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Doctors and the Pharmaceutical Industry

Sir,

I respect the argument advanced by Dr Taylor (December *Journal,* p.825) against any acknowledged association between the College and a pharmaceutical company. It has all the intellectual strength of an uncompromising ethical stance—and the weakness. In practical terms it would result in a substantial increase in membership subscription to maintain the same level of services and activity, centrally and in the faculties, the successful Annual Symposia costs would double and there would be no possibility of the College mounting the WONCA Conference in London in 1986.

In Edinburgh, home of John Knox, town and gown have managed to accept benefactions with grace and without favour. Edinburgh graduates receive their degrees in the impressive McEwan Hall, while Edinburgh citizens receive cultural nourishment in the Usher Hall, the centrepiece of the Edinburgh International Festival. These benefactions arose from the profits of brewers and no doubt have promoted their products. The educational and cultural assets which they provide, however, far outweigh any tendency to exacerbate what is an admitted national weakness.

The Royal Colleges and University which together administer this postgraduate centre have not been inhibited from acknowledging the company that provided it and no doubt the postgraduate students from all over the world who come here are made more aware of that company name, but the lecturers who teach therapeutics are more likely to promote the cause of generic prescribing than proprietary medicines.

Ivory towers are intellectually satisfying, but who provides the books?

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What Sort of Fellow?

Sir,

The March issue of the College *Journal* contained an editorial on the subject of appointment to Fellowship of the College. To this reader the only result has been that the author of the leader has lost the distinction of being the only general practitioner associated with the editorial board *not* to have been awarded the Fellowship.

We cannot all write leaders but could your readership be informed if the Awards Committee is beavering away producing an equitable system of awarding the Fellowship—or does secrecy and the hint of nepotism help the College maintain an upper crust image *vis-à-vis* consultants and their merit awards?

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Tablets and Capsules that Stick in the Oesophagus

Sir,

I would like to draw attention to a hazard of taking tablets which, in spite of an article on the subject in the Drug and Therapeutics Bulletin,[1] does not appear to be generally appreciated by the medical profession.

A 48 year old woman was taking tetracycline (Achromycin) 250 mg tablets twice daily as a prophylaxis against recurrent boils. One night she took a tablet immediately before lying down to sleep and neglected to take a drink of water with it. She was awakened later with pain and a sensation as if the tablet were sticking in the mid-chest region. She rose and took a drink and ate some bread, but the pain persisted. For the following week she was unable to eat solid food, or even to drink, without severe discomfort. On the seventh day a barium swallow was carried out which showed a kink in the oesophagus at the level of the aortic arch, at the site of the pain, and oesophagoscopy showed several ulcers at about 25 cm from the mouth. The patient was treated with antacids and the symptoms disappeared about the 12th day.

Interestingly, some years earlier, this woman had had an oesophagoscopy for an attack of pain on swallowing occurring at a lower site in the chest. No abnormality had been found. At that time she had been taking aspirin and codeine for pleurisy due to tuberculosis. In retrospect, it seems likely that a tablet, aspirin, was again responsible for the oesophagitis.

Some drugs, such as emepronium bromide and potassium chloride are known to cause oesophageal ulceration, but antibiotics much less so. However, there is now a large number of reports of antibiotics causing oesophagitis, particularly those which cause symptoms in the lower gastrointestinal tract; tetracycline, doxycycline, clindamycin and erythromycin.[1]

The effect of aspirin and other nonsteroidal anti-inflammatory drugs on the oesophagus is also important in view of the increasing incidence of dysphagia in elderly patients, especially those with long-standing rheumatoid arthritis, many of whom are being found to have benign oesophageal strictures requiring dilation.[2]

Oesophageal smooth muscle dysfunction, shown on barium swallow, is common in elderly patients. Such people are also frequent recipients of large quantities of antibiotic and anti-inflammatory drugs. These may be taken in recumbent positions or in situations such as the street where a drink is not available. It is surprising that pain due to oesophageal ulceration is not more common. Doctors should pay more attention to telling patients how to take their drugs, and labels on medicine bottles should include instructions to take tablets in an upright position with a drink.

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References

1. Tablets and capsules that stick in the oesophagus. *Drug and Therapeutics Bulletin* 1981; **19:** 9.
2. Hellier SR, Fellows IW, Ogilvie AL, Atkinson M. Non-steroidal anti-inflammatory drugs and benign oesophageal stricture. *Br Med J* 1982; **285:** 167-168.