Information was also recorded concerning prescribed antibiotics and the results of bacterial culture.

Figure 1 shows the percentage of the total urine specimens examined that contained antibiotics. Those samples containing antibiotics where antibiotics were and were not stated on the request form are also shown as a percentage of the total urine specimens examined.

The percentage of urine specimens containing antibiotic substances that gave a positive culture was 16.0%, with all but one of the bacterial isolates being resistant to the agent detected in the corresponding urine sample. The percentage of all urine specimens received from general practice patients with a positive culture was 18.8%. The high frequency of positive culture for specimens containing antibiotics suggests that many specimens were sent to the laboratory after symptoms had persisted, despite treatment. The higher frequency of positive cultures from specimens sent with request forms that did not state any antibiotic therapy compared with those that did implies that in some cases at least, the patient may have returned to the doctor after an unsuccessful attempt at self-treatment.

The assumption that all urine samples containing antibiotics are 'nonsense urines' is not correct for specimens received from general practitioners in the Leeds area.

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Nurse-run asthma clinics in general practice

Sir,

Recently general practitioners have been criticized for the lack of diagnosis, undertreatment and poor follow-up of asthmatic patients.[1] While it is generally accepted that asthma should chiefly be managed in general practice, identification of patients at risk, definite diagnosis, effective treatment, systematic follow-up and patient education are all essential for successful management. We now have the drugs to treat most patients effectively and should be aiming for long-term preventive treatment rather than the inherited system of 'crisis intervention'.

Ten years ago I would not have had the temerity to suggest that nurses could, and would, successfully run hypertension clinics in general practice. Even 18 months ago, I did not realize how receptive general practitioners would be, both to the concept of nurse-run hypertension clinics[2] and to a hypertension training programme for nurses. It would seem that many general practitioners now feel that full advantage should be taken of the underutilized nursing talent available in general practice.

We know that diabetic and hypertension clinics work in general practice[3] but what about asthma? One of our partners, Dr Robert Pearson, who has a special interest in respiratory medicine, felt it was a natural progression to see whether a suitably trained nurse could run an asthma clinic which would be complementary to our other clinic work.

With much encouragement from our local chest physician, Dr Lawford Hill, I spent a useful week on his chest unit and spare moments were spent in reading and 'sitting in' on asthma consultations in the practice. We set up a practice asthma register which now has 500 patients (5% of the practice population).

Our previous experience had taught us the importance of having a structured system and we developed a diagnosis and management flow chart and an asthma assessment/follow-up card to fit FP6.

The nurse-run asthma clinic operates by receiving patients by referral within the practice. Forty minutes are allowed for an initial assessment and 15 minutes for follow-up appointments. Apart from peak flow measurements, spirometry, reversibility and exercise tests and checking inhaler technique, much time is spent on patient education. Each patient is provided with a booklet and an individual advice card. Although our aim is to achieve maximum patient independence, and many of the patients have their own peak flow meters, they are encouraged to contact the asthma clinic if they run into trouble.

The nurse's activities could, of course, be kept to a minimum (for example, just recording peak flow measurements and teaching inhaler techniques). We chose to see how much responsibility could satisfactorily be given to a nurse. From my point of view it has been fulfilling, rewarding and stimulating — I am actually making people feel better.

Some doctors may feel threatened and resist the 'handing over' of their patients to a nurse-run clinic. The nurse must take care to show she is not usurping the doctor's position and that the emphasis is on teamwork with no conflict of interest. Mutual confidence and trust and the readiness of the doctor to give advice and help are vital.

It would have been impossible to pioneer a nurse-run asthma clinic without Dr Pearson's support, encouragement and particularly his tuition. Recently, a national programme of asthma study days for practice nurses has been initiated — the concept is exciting. However, its success will ultimately depend on doctors giving 'continuing' support and encouragement to their nurses after the course.

In the future 'specialist clinic nurses' could be employed by general practitioners. These nurses would need to be academically inclined and interested in integrating preventive care with therapeutic care, as well as being capable administrators and organizers. They would fulfil, in my opinion, a very real need in general practice for the care of not only the diabetic and hypertensive patient but also the asthmatic.

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Examples of special record cards, diagnosis and management flow charts and patients' treatment cards can be obtained from Mrs G.R. Barnes at the above address. Please enclose a stamped addressed envelope 10" x 7".

Advice on applying for a trainee post

Sir,

I advertised recently for a general practitioner trainee and the replies came rolling in. I was disappointed to find that the general standard of replies was so poor. Over 80% of the applications were so badly presented that I was tempted to discard them without a second look. Every year there are articles in the medical press stating the basic guidelines for job applicants in preparing their application so that they maximize their chance of overcoming the first hurdle and earning

an interview. With no apologies for repetition, since the advice is so obviously needed, I offer the following suggestions:

Curriculum vitae. This should be cleanly typed on good quality paper and clean photocopies should be made (even if you have to pay for them); an illegible CV can ruin your chances. Keep your CV up to date. Do not leave a space at the top in which to scrawl your application in biro. The following information should be included:

1. Name, age and photograph.
2. Current address and telephone number.
3. Nationality.
4. Marital status/children.
5. Driver's licence.
6. Medical qualifications.
7. Any prizes or extra qualifications obtained.
8. Registration with the General Medical Council or the Medical Defence Society.
9. Employment record in chronological order (specify if locum posts). Do not write a long description of the normal duties of a surgical houseman but do make a note of any unusual activities, for example, if you have been in a burns unit or a family planning clinic. Include any general practice sessions and locum posts, as well as details of your present post and when it ends.
10. Referees. First, at least make sure that you have their permission to give their name. Obviously, consultants for whom you have worked in this country are the best people to ask.

Covering letter. This is vitally important. A good letter from an average candidate is much more likely to gain an interview than a poor letter from an academically distinguished applicant. This letter should give the trainer some idea why you want to become a general practitioner, why you have chosen his or her training practice and what you enjoy in the way of activities outside medicine. Family details are important, such as any permanent home in the UK if you are a foreign applicant, and your eventual career plans. If you have a working spouse it is common sense to include their future plans in the letter if the appointment will mean moving to a new area. Never use a photocopied covering letter — this is very bad form as it indicates to the employer that you have unsuccessfully applied for hundreds of jobs and it will not convince him or her that the job they are offering is very important to you.

Special cases. Foreign doctors, particularly those applying for trainee posts, are in a difficult position, especially if they have been general practitioners in their own country and now need a one year training post in order to comply with our vocational training regulations. I have had many replies from older Sri Lankan general practitioners who have come to the UK recently and who need to complete a year in training. I think it is essential for these doctors to talk to their vocational training course organizer and the regional adviser who may be able to help them. There is a lot of pressure on good training practices from UK graduates. Irish graduates (there are no one-year training posts in the Republic of Ireland) should indicate their willingness to travel to an interview, as there is little point in applying from a long distance if there is no chance of attending for an interview.

Single doctors. If you have been reading the medical newspapers recently you will have seen mention of possible 'discrimination' against single doctors because they have no one to answer the telephone and may be 'emotionally insecure'. In these days of answering machines and cohabitation there is no excuse for employers to reject a doctor because he or she is single. It may be important to convince your prospective employer that you will buy an answering machine if necessary (£99 buys a reasonable one and it is tax deductible). Being married does not automatically provide a telephone answering service but it is useful if the spouse will help out on nights and weekends on call.

Some 'howlers' to avoid:

I do not enjoy being addressed as 'Dear Sir'.

I am not impressed by a covering letter being written on a half-sheet of file paper roughly torn across.

Poor English is inexcusable — there are plenty of people willing to advise you on the finer points of letter-writing.

Dirty, fingered and illegible applications go straight into the bin — I do not want my patients' notes treated like this.

Do not hound your potential employer with phone calls before your application has had time to arrive. Imagine 70 applicants for one job all phoning up for information about the practice during Monday morning surgery! Questions about the practice should be saved for the interview. By all means check the Medical Directory and ask the Family Practitioner Committee for some background information.

I do hope that this helps to avoid some of the ghastly applications which I received. Lastly, a note to the poor fellow who mentioned he had applied for over one hundred trainee vacancies — this should tell you something and, if not, please go and speak to the local vocational training organizer or regional adviser.

HELEN CLAYSON

The Surgery
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Forum

Sir,

Since January 1985 the Irish College of General Practitioners has been publishing a monthly newsletter known as *Forum* or the ICGP Review, which is sent to all members and associates. The initial function of *Forum* is to act as a means of communication and exchange of ideas among members of the ICGP. To achieve these aims, it is important to receive as broad a base of contributions as possible from among the membership.

Anybody interested may contact the Editor, Dr Charles Daly, at the address below.

CHARLES DALY

The Surgery
Tullow
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Spiritual healing and general practice

Sir,

The Churches Council for Health and Healing has a joint working party with the Royal College of General Practitioners. One of the crucial matters relevant to our discussions is that of validation of spiritual healing. This requires closer cooperation between the clergy and medical practitioners. One of the facets of this inter-relationship is the meeting of doctors and clergy at a local level. I should be most grateful for information from colleagues who attend a local doctor/clergyman or who have a member of the clergy or other spiritual counsellor attached to the practice.

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Corrigendum

Familial hypercholesterolaemia

In a letter on familial hypercholesterolaemia published in the June *Journal* the list of signatures should have included the following physicians and general practitioner with a special interest in disorders of lipid metabolism: J. Betteridge, P. Durrington, P. Gibson, E. Gowland, C. Marenah, D. Orrell, P. Pritchard, J. Reckless, J. Shepherd, K. Taylor, R. West and A. Winder.