In 'doing the rounds' of the partners, the patient's notes become bulkier with each exasperated written entry and negative investigation, and in the process the patient acquires a stigma which is not merely the result of his own personality. He gradually loses all hope of being taken seriously, for as he relentlessly turns up he increases the doctor's bile which in time leads to the jaundiced eye.

Our own attitudes, the way we dispense and share care within our practices, may therefore be the biggest remediable factor in influencing our own workload. Next time we look through a fat folder and feel despairing, we should reflect on the fact that we may be looking into a mirror of our working methods.

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Sir,

I was interested to see the paper by Dr Westhead (July *Journal,* p.337) which set out to study the medical, psychological and social characteristics of frequent attenders. He noticed that the main social characteristic of frequent attenders, which was different from controls, was marital breakdown. This conclusion agreed with my own research.[1]

I felt the higher instance of marital breakdown was perhaps due to the difficulty patients have in sustaining relationships as I also noticed among my fat folders that there was a higher instance of those patients having changed their allegiance between one doctor and another.

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Reference

1. Goodridge DMG. An analysis of fat folders. *J R Coll Gen Pract* 1982; **32:** 239-241.

Sir,

In Dr Westhead's excellent study of frequent attenders in general practice (July *Journal,* p.337) it was interesting to note that he based his definition of frequency on four years of attendance information, unlike most studies which have been based on attendance data over 12 months. The potential problem with the latter approach is that attendance characteristics may be a temporary feature and high attenders one year may not necessarily be so in previous or later years.

Several years ago we examined the stability of attendance patterns by looking at the attendances of 698 patients registered at Howden Health Centre, Livingston, West Lothian over a three-year period. To do this we had to follow attendances for individual patients and not just examine the overall attendance patterns In the practice. Correlation analysis demonstrated stability with high and low attending patients tending to remain in these categories over the three-year study period.

Since there is very little published information on this question it would be interesting to know if Dr Westhead was able to study this aspect of attendance patterns.

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Laughter and medicine

Sir,

Dr C.P. Elliott-Binns' editorial on laughter and medicine (August *Journal,* p.364) was a timely and welcome reminder of the interactions of the two, which have long fascinated me. The 'lead balloon' response by patients to attempts at iatrogenic jocularity seems often to give worthwhile insights into personality, but these are, I agree, better not attempted twice. Another interesting aspect of humour in the consulting room is the way patients often use it to conceal underlying problems which are too difficult to openly discuss. I remember particularly, one patient who successfully avoided discussion of hypogonadism due to Klinefelter's syndrome by a smoke screen of 'humour' which fooled me for quite a time.

A more specific therapeutic use of humour is in the treatment of free-floating anxiety episodes. Along with insight counselling, 'floating' and non-control techniques, I find that teaching the patient to learn to laugh at the swelling panic — often by them giving it a funny name — is a useful defusing ploy which helps many.

The description of Ventis' case of the girl at the dinner party, and her successful use of amusement to overcome an external worry, matches a similar use of humour on vaguer internal anxieties.

It is difficult to fear that at which we can also laugh.

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What sort of doctor?

Sir,

The authors of *What sort of doctor? Report from general practice 23,* have missed the main point of what makes a good doctor. Good doctors cure their patients: if there is no cure, at least they comfort them.

What is the point of being accessible if you are ineffective? What is the point of being a good communicator if you communicate the wrong message? What is the point of writing brilliant referral letters if you are referring the wrong patients? What is the point of examining patients if you cannot elicit their physical signs?

First of all we must be competent — only then does it make sense to strive to be sensitive. Therefore, any assessment of quality of care that does not contain questions like 'Can you feel this lump?' is vacuous.

The following idea aims to allow the direct testing of clinical acumen in a way which is neither threatening nor difficult to arrange. The idea is that the assessors should be chosen for the physical signs they exhibit and not for their enthusiasms for furthering College ideals.

With the large numbers of doctors now in the College, it should be possible to compile a register for all the most important physical signs. There must be hundreds of us with murmurs, retinopathy, jaundice and all the stigmata of chronic liver disease and so on. What a wasted resource! Now we have the College proposals for assessing quality we should inject them with a sense of clinical acumen by pooling our pathologies and conducting physical examinations on our assessors. This way of selecting assessors would, at a stroke, remove the prevalent notion that assessors are likely to be 'holier than thou' College enthusiasts. Since it is stated that there is no element of pass or fail in the assessment, any threat is removed and an element of unpredictable fun is introduced.

To start the ball rolling I offer my practice for inspection by anyone with a good physical sign for me to elicit.

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