and slightly confused assertion, a mistrustful desire to centralize authority. It is disappointing and it will not do.

Perhaps the 60-odd doctors whose names appear on page ii as being collectively responsible for the statement do not agree with these views, or perhaps they erred by consulting the membership with undue haste in the height of the holiday period. I had thought of sending photostats of this to each of them to enquire, but will settle for this form of protest. After all, we cannot take it back now. It is only open to us to be more careful in the future.

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Professional confidentiality: the patients' view

Sir,

The concept of professional confidentiality is of primary importance in the doctor–patient relationship, endorsed from the time of our admission to the profession by the Hippocratic oath. The concept of confidentiality has changed since the introduction of medical records. The recording of patients' personal information may result in their reluctance to impart clinically important yet delicate details.[1] Some practitioners, however, may be obsessively preoccupied with the confidentiality of the current consultation. Yet, is this what the patient always expects?

In a prospective series of 1000 consultations the attitudes of patients to the confidentiality of a consultation were assessed by examining their behaviour in opting for an open or confidential consultation. The patients were called from the waiting room by the practitioner, and led down a corridor to the consulting room. On entering the room the practitioner immediately sat at his desk and observed the patient's spontaneous behaviour with regard to closure of the consulting room door. On passing down the corridor, the patient had passed people waiting outside the practice 'treatment' room, and was thus aware of the possibility of being overheard during the consultation. Indeed, in some consulting rooms it was possible for the patient to see others waiting outside the open door during the consultation.

Of the 1000 consultations a total of 678 (67.8%) were carried out in an open room — 197 male patients (52.9%) and 481 female patients (76.5%) chose a consultation of this type. The results obtained with respect to diagnostic category are shown in Table 1. For urogenital and gastrointestinal conditions male patients were unanimous in their choice of consultations in a closed room; these conditions may conform to the male concept of socially undesirable illnesses. For female patients confidentially assumed less importance for these conditions, especially for those under 50 years of age. For psychiatric conditions both male and female patients chose consultations in a closed room with the exception of six women who were diagnosed as suffering from endogenous depression — a condition which was not noted to occur in the group of males studied. A seasonal variation was noted which may perhaps be temperature related — closed consultations varied between 19% in the summer and 40% in the winter.

Table 1. Patients' choice of a closed or open consultation room by diagnostic category.

	Total number of patients	Number of patients by diagnostic category						
		RT	UG	GI	MS	Derm	Psych	Misc
Male patients								
Open consultation	197	127	0	0	14	23	0	33
Closed consultation	175	53	27	46	13	10	13	13
Total	372	180	27	46	27	33	13	46
Female patients								
Open consultation	481	250	47	43	57	22	6	56
Closed consultation	147	44	13	24	10	5	27	24
Total	628	294	60	67	67	27	33	80

RT = respiratory tract including ear, nose and throat. UG = urogenital including anti- and post-natal, gynaecological and contraceptive consultations. GI = gastrointestinal. MS = musculoskeletal. Derm = dermatological. Psych = psychiatric. Misc = miscellaneous including cardiovascular, ophthalmological and other conditions not included above.

While it should be recognized that many variables are involved in the decision by patients to leave the consulting room door open, this study suggests that patients do not always seek confidentiality in a consultation. Some patients may consider that being observed in consultation with their doctor endorses their 'sick role'.[2] Also, it should be remembered that some patients have already related their problems to others while in the waiting room.

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Patient satisfaction

Sir,

During the period of the College's quality initiative we would like to draw attention to another side of the quality initiative — that of patient satisfaction. We believe that it is axiomatic that a satisfied patient is one whose expectations have been either met or addressed.

In industry, there is a marketing technique where all parties in a transaction are asked their expectations, and what they believe the other parties expectations are. By analysing the results any mismatch between what is supplied and what people want can be determined.

It has long been reported by many authors,[1-12] that a high percentage of patients are satisfied with their general practitioner. However, it was our experience, listening to people talk in check-out queues and in other public places, that there was a great deal more dissatisfaction than appeared in print. We sought to discover if principals in general practice and their staff knew or had thought about their own and their patients' expectations; we also asked the doctors' patients what were their expectations of the medical encounter.

To overcome methodological difficulties, we approached practices at random (80% refused), selected four group practices and approached a few of their patients selected at random and interviewed them in their homes (90% of those located agreed to be interviewed). We thought it important to talk to patients in their homes as it is believed that patients are reticent about criticizing their own doctor, but not doctors in general.

The questions asked of doctors, receptionists and patients were:

1. What do you expect of your doctor/receptionist/patient?
2. What does the doctor/patient/receptionist expect of you?
3. Do the physical surroundings of the surgery matter?
4. What were your expectations from your doctor/practice and have these expectations changed?
5. How do you see the differences between National Health Service and private treatment?
6. How will you/a patient complain? How would you/the patient express this?
7. Are expectations different in the care of children?
8. What was your training? (doctor/receptionist)
9. How do you know if the patient is satisfied? (doctor/receptionist)
10. How do you see the role of doctor in the community?

The interview was recorded and later transcribed. The transcripts were then analysed. A total of 31 patients, 12 receptionists and 13 doctors were interviewed in four different group practices. To question 4 about expectations, there was a marked mismatch. Doctors and their receptionists thought that patients wanted to be cured and made better. Seventy per cent of all patients however, mentioned that they wanted to be listened to and taken seriously. It seems that patients were more interested in the process than the outcome. Interestingly, patients were right about what they thought doctors expected of them.

Receptionists tended to follow their doctor's views of patient expectations. However, no doctor had thought about what the receptionist expected of him; all the receptionists thought they wanted more support from the doctor. No patient thought that they had any responsibility to the receptionists, but receptionists expected patients to know the system and to abide by it.

There is other indirect evidence to suggest that patients think of the process of the medical encounter as equally or more important than the outcome. Klein in his book on patient complaints found that a high percentage of the complaints concerned the process of the medical encounter.[13] Recently a patient sued an obstetrician and won her case — she is reported to have said afterwards that she only sued because he did not say he was sorry.

We believe that as part of the quality initiative each practice should discover for itself (preferably using outside help) what its patients and staff expect. It may also be important to explain to patients what staff and doctors expect of them.

Such an exercise has educational benefit — it will also benefit patient care and satisfaction should be improved to the benefit of all.

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Monitoring of chronic disease

Sir,

In his address to the College Spring Meeting in 1985, the then Chairman, Donald Irvine, rightly stressed the importance of the general practitioner's role in chronic disease. Diseases such as hypertension, diabetes, asthma and rheumatoid arthritis provide a large part of this workload. In monitoring these conditions I have found the need for a flow chart. Previously drug companies used to supply cards for hypertension, which I adapted for use in other diseases. However, this source has now ceased, and I have designed a universal flow chart, which Duphar Laboratories Ltd kindly printed for me. The front gives patient details and lists some investigations which are particularly useful in hypertension and diabetes. The reverse side (Figure 1) is the real flow chart, and should provide parameters to measure and record in all the chronic diseases mentioned. It can be adapted for other measurements such as blood urea and thyroid functions.

The card has been in use in my practice for the past six months, and few snags have arisen. The weight scale in stones does not show small differences very clearly, but by using kilograms these differences can be enlarged.

I wish to encourage other practices to use these cards which are intended for Lloyd George envelopes, although no doubt larger A4 sheets could be designed. They extract information which gets lost in the narrative of the continuation cards, as well as giving a much clearer picture of changes in the important measurements in chronic disease.

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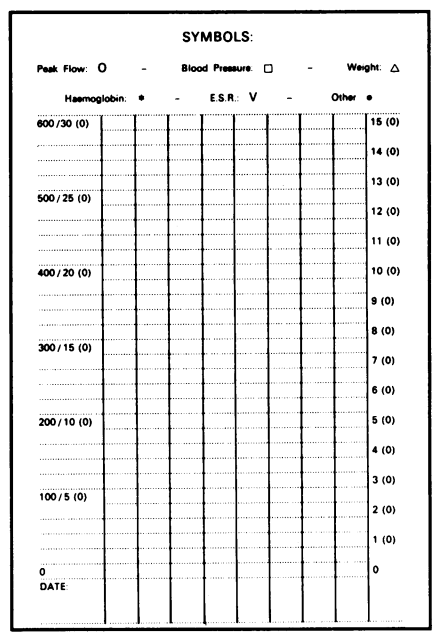

Figure 1. *Reverse side of universal flow chart.*

Characteristics of medical students wanting to become general practitioners

Sir,

We wish to present some data on the characteristics of medical students seeking a career in general practice compared with those opting for other specialties.

As part of a study into the development of student attitudes towards a career in psychiatry,[1] 498 students in six medical schools completed a questionnaire which included questions on respondents' sex,