

the doctor would be comforted by the reassuring sight of an open door.

The marked seasonal variation, with 81% of patients opting for an open consultation during the summer months (compared with 60% in the winter) is as likely to reflect the need for air-conditioning in the consulting rooms as it is the desire for confidentiality.

While this was an interesting study, it appears to have posed more questions than it has answered. It would have been more useful had an attempt been made to determine what factors had led to the decision to leave the door open or closed.

G.A. NORFOLK

Medical Services Division
Rezayat Company Ltd.
P.O. Box 90
Al-Khobar 31952
Saudi Arabia

Accessibility of GPs: a patients' liaison group survey

Sir,
The North-West England Faculty of the Royal College of General Practitioners has formed a patients' liaison group mirroring locally the national patients' liaison group, composed of members of the College and representatives from local community health councils and one patient participation group in the region. We considered how we could best contribute to the evaluation and subsequent improvement of general practitioner care in the north-west of England. One of the topics the group has chosen to study is patients' perceptions of the accessibility of general practitioners.

In November 1985 the group commissioned a pilot study with random samples of 200 adults, 100 in each of two constituent districts. Structured interviews were carried out in respondents' homes by trained professional interviewers using questionnaires. The samples contained more women and older people than expected. The questionnaire invited comment about a range of topics, including travel to the surgery, contact arrangements with the practice and perceived attitudes of receptionists and general practitioners.

Important general findings from this pilot study were: first, many respondents wished to be able to talk directly to their general practitioner by telephone; second, the number of patients preferring an appointment system was not much greater than the number preferring an 'open system'; third, there was a large minority

of patients expressing dissatisfaction with various aspects of the service.

Almost two-thirds of the respondents said they always made an appointment to see the doctor. Nearly three-quarters of those using practices with appointment systems said they could consult any of the doctors. Some patients preferred a particular practitioner and of these a third said they had to wait until the next day and one in five had to wait two days. However, nearly a quarter waited three days or more. Twenty per cent of patients found this wait unsatisfactory.

Over a third of patients who had made appointments said they waited less than 15 minutes in the waiting room. A similar number had to wait 15 to 30 minutes, but a quarter had to wait longer. One in five patients were dissatisfied with this.

Nearly a third of the respondents who needed to make an appointment had tried to see the doctor urgently. Of these, the majority were seen quickly, although a handful had to wait until the second day. Eighty-five per cent were satisfied with the response to requests for urgent consultations. Just over a third of patients (36%) could go to their doctor without having to make an appointment. A quarter of them were dissatisfied with the general level of accessibility.

General preferences for contact arrangements were almost equally split between being able 'to go along and wait' and booking to make an appointment to see the doctor. Only a few preferred a mixed system. Most people found existing surgery hours convenient. Almost 20% wanted additional hours, the most popular being on Saturday morning.

Four out of five respondents had a telephone in their house but only 25% had ever tried to telephone the general practitioner to discuss a problem. Of these, most found they could talk directly to the doctor without difficulty. The majority (67%) said they would like to be able to telephone and talk directly to the doctor.

Almost half the respondents had asked for a home visit in the last year and nearly all had had no difficulty in getting one. About one-fifth had tried to contact their doctor out-of-hours in the last year and most of them said the doctor arrived within an hour. Eight respondents waited longer than two hours. Forty-five per cent said the service was quick but 15% thought the delay seemed too long and 40% that it seemed very long.

When respondents were asked in an open question if anything would make it easier for them to see the doctor 72% could think of nothing. Asked about particular items 47% of respondents re-

quested shorter waits in the surgery, 45% wanted the facility to talk to the doctor on the telephone, 35% shorter waits for appointment slots, 27% quicker response to emergency calls, 22% longer surgery hours, 16% a better telephone system and 12% 'better receptionists'.

In many respects the results from this pilot study are similar to the larger national studies carried out by Cartwright and Anderson¹ and Ritchie and colleagues.² There are, however, differences in some aspects which justify further study of inter-district variations and strengthen the case for more locally focussed studies. The patients' liaison group proposes to extend the survey to most districts in the North-West Region and is currently seeking support for this. The group would welcome comments from others who may have carried out similar work.

DAVID ALLEN

RALPH LEAVEY

BERNARD MARKS

RCGP North-West England Faculty
Rusholme Health Centre
Walmer Street
Rusholme M14 5NP

References

1. Cartwright A, Anderson R. *General practice revisited: a second study of patients and their doctors*. London: Tavistock, 1981.
2. Ritchie J, Jacoby A, Bone M. *Access to primary care*. London: HMSO, 1981.

Exercise and sport

Sir,
Over recent years there has been a general increase in public interest in exercise and sport. At the end of 1985 I attempted a survey of how many patients presented to their general practitioners in the Dumfries and Galloway Health Board area with problems related to exercise and sport (during the month of November). As only 26 of the 120 practitioners in the area replied, firm conclusions are not possible.

I write to mention points which seem of particular interest:

1. Six of the 52 cases presented were considered by the reporting practitioner to be preventable.
2. Eleven of the 52 cases were injuries to the head and face, with three concussions.
3. Five of 10 cases in females were injuries to the hand and wrist.

If these figures are generally representative and could be substantiated, an area of prevention which has been little explored offers itself.¹

R.J. ROBERTSON

Charles Street Surgery
Annan
Dumfriesshire

Reference

1. Macaulay C. Why not sports medicine in general practice? *J R Coll Gen Pract* 1982; 32: 700-701.

Changes in obstetric care in breech births

Sir,

Is obstetric care improving for the breech infant, and if so, in what way? Obstetric records dating back to 1937 were discovered in Barnsley District General Hospital referring to labour suite activities in the original St Helen's Hospital. These were analysed with respect to singleton breech deliveries, their mode and outcome, and compared with singleton breech deliveries taking place in 1982. The current population of the Barnsley area is 233 000. In the early 1940s, three-quarters of deliveries took place at home, whereas nowadays the figure is around 2%.

Hospital breech deliveries between 29 December 1937 and 26 November 1941 were compared with those between 31 October 1982 and 31 October 1984. In the earlier period, 40% of the mothers with

a breech infant were primigravid, and in 1982-84, 59%. Equivalent figures for 'grand' multiparas (gravid five or more) are 46% and 9%. Table 1 illustrates the preliminary findings.

The mode of delivery was analysed and the degree of obstetric interference assessed. In Table 2 a complicated delivery refers to one where forceps were used or mechanical difficulties arose, and excludes Caesarian section. An uncomplicated delivery is a straightforward one where the above does not apply.

The difference in the modes of breech delivery between the two periods is striking but not unexpected. The trend towards elective abdominal delivery for the breech infant is illustrated; the policy established by Wright¹ that 'all viable (breech) infants be delivered by Caesarian section' has been favoured until very recently. Amiel² considered vaginal delivery to be safer in many ways, and Anderman³ suggested that carefully selected term breech babies of primiparas could be delivered vaginally with similar perinatal mortality rates to those born abdominally.

'Complicated' deliveries in 1937 included the attachment of weights to the foot in a footling presentation or placenta praevia, and bipolar podalic version. However, it seems that more than half of breech deliveries in this period were uncomplicated.

There was a higher stillbirth rate in 1937-41 (386 per 1000 breech births compared with 6 per 1000 in 1982-84),

the causes being cord prolapse, skull fractures, pre-eclampsia, version and obstructed labour. Maternal deaths were variously caused by shock, pyrexia, cardiac failure and gas gangrene.

This small study highlights the dramatic improvement in maternity services over the past 40 years, and illustrates trends in obstetric care.

JENNIFER A. STEPHENSON

Walkley House Medical Centre
23 Greenhow Street
Sheffield S6 3TN

References

1. Wright RC. Reduction of perinatal mortality and morbidity in breech delivery through routine use of Caesarian section. *Obstet Gynaecol* 1959; 14: 758.
2. Amiel GJ. Breech: vaginal delivery or caesarean section? *Br Med J* 1982; 285: 1275-1276.
3. Anderman S, *et al.* Is term breech presentation in primigravida an absolute indication for cesarian section? *Eur J Obstet Gynaecol Reprod Biol* 1984; 18: 11-16.

General practitioners' knowledge about radiology

Sir,

I thought that your readers might be interested in the results of a questionnaire survey carried out by our radiology department recently in an attempt to assess how well-informed were our local general practitioners about both the 'bread and butter' X-ray examinations and also the newer imaging techniques. A total of 75 general practitioners were circulated and 54 responded; the sample included a wide range of practices — service and civilian, urban and rural. A second much shorter questionnaire was given to 50 consecutive patients referred by general practitioners for outpatient procedures, mainly barium studies and intravenous urography, in which they were asked how much information they had been given about the examination by their own doctor, and whether or not they found it useful or desirable.

Of our general practitioner sample 14 (26%) felt that they had insufficient knowledge of the everyday procedures such as bariums and intravenous urograms to inform their patients adequately, and it is possible that this is an underestimate since there have been changes in the way we perform even these basic examinations over recent years. Forty-six doctors (85%) felt that the general practitioner needs to know something about the new 'high-tech' imaging methods, but 43 (80%) said that they had insufficient knowledge in this area.

Table 1. Comparison of data on breech births in 1982-84 and 1937-41.

	1982-84	1937-41
Total hospital births per year	2572	323
Singleton breech births (%)	166 (3.2)	57 (9.2)
Perinatal mortality rate (per 1000 hospital births)	9.5	212
Maternal mortality rate (per 1000 hospital births)	0	12.9
Breech perinatal mortality rate (per 1000 hospital births)	48	456
'Breech' maternal mortality rate (per 1000 hospital births)	0	53

Table 2. Comparison of degree of obstetric interference in breech births in 1982-84 and 1937-41.

	Percentage of breech births					
	1982-84			1937-41		
	Prima-paras	Multi-paras	Total	Prima-paras	Multi-paras	Total
Complicated deliveries	5	24	13	35	53	45
Uncomplicated deliveries	6	10	8	61	47	53
Caesarians						
Total	89	66	79	4	—	2
Elective (% sections)	63	42	56	—	—	—
Emergency (% sections)	37	58	44	—	—	—