

Eighty five per cent of respondents were in favour of community based hearing aid dispensing, 19% had previous ENT training and 41% were willing to undertake further training. Among the 30 doctors who had previous ENT training three doctors had had 12 months training, eight doctors six months, seven doctors three months and 12 less than three months.

There is thus strong support among general practitioners for the provision of hearing aids in the community and nearly half the respondents in this study would be willing to undergo further training. A trained general practitioner would be able to remove wax from the ear and differentiate the types of otitis media, and also detect patients with asymmetrical hearing loss.

One in five patients seen in ENT clinics are patients who were referred for hearing aids;<sup>3</sup> decentralization of this service would save valuable time in busy ENT clinics. This faster and more accessible service would thus benefit the consumer.

The provision of hearing aids in the community will only require the involvement of a small number of interested and adequately trained general practitioners in any one district with the support of community audiology technicians. Vocational training in otolaryngology should be oriented towards practical aspects of the provision of hearing aids with the aim to create a hearing aid list analogous to the obstetrics list with financial incentives being offered to the practitioner.

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### Computers in general practice: patients' views

Sir,  
There has been a considerable amount of talk about the need to computerize general practice. Family practitioner committees are mainly computerized, and hospitals and laboratories are also moving in this direction. Much has been heard from the present government of their intention to have a computer on the desk of every

general practitioner in the near future. The intention is to allow easy access to waiting lists, family practitioner committees, and make reasonable and speedy audit more feasible.

At the present time only 32% of practices are computerized while according to VAMP another 33% have declared their intention to buy a computer in the next year.<sup>1</sup> It is possible that the future contract for general practitioners will encourage more practices to become fully computerized. Indeed it is difficult to see how practices without a computer will easily achieve targets and produce sensible audit.

One group of people have been largely left out in the debate about computers in general practice. Patients usually put up with whatever is done in practices as long as it is designed to be helpful and is not overtly threatening. A computer on the desk, however, could appear threatening. A study by Rethans and colleagues<sup>2</sup> suggests that patients are on the whole in favour of personal computers in the surgery. In a study by Potter<sup>3</sup> in 1981 nearly 30% of patients thought that the presence of a computer might adversely influence the consultation and some patients even stated that they would leave the practice. Cruikshank<sup>4</sup> in 1984 reported that over half of the responders thought that the presence of a computer in general practice would adversely affect the personal touch of the doctor, whereas Pringle and colleagues,<sup>5</sup> found that 17% of patients were opposed to computerization largely on the grounds of possible loss of confidentiality.

A recent simple questionnaire study in general practice looked at whether patients' attitudes had changed in this country as a whole, now that computers are more widely used and now that more patients have some experience of computers in medicine and, frequently, at home. Special note was taken of patients' attitudes towards the desk top computer, and an attempt was made to discover what their fears were.

A total of 1090 replies were received from patients of several members of the Janssen research group. The results showed that 93% considered that computer generated letters and recall were advantageous, while 74% thought that standards of medical care would improve. Eighty four per cent had no objections to the storage of medical records on computer although several raised the question of confidentiality.

Regarding the use of a computer on the doctor's desk, 84% of patients had no objection to the use by the doctor to check records, but only 76% were happy to have

the computer used as part of the consultation.

This simple study has shown that while the majority of patients do not mind the use of computers in practices and are not threatened by them given certain safeguards, there are still a significant minority (one in four) who are unhappy about the use of a computer during the consultation. To gain the full support of our patients it appears that there is still considerable room for further education. Perhaps the most important message is from one patient's comment that computers should complement but not replace the general practitioner.

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### Time availability in the consultation

Sir,  
I was most interested in the study of the effect of time availability on the consultation by Ridsdale and colleagues (December *Journal*, p.329). I became interested in the relationship between consultation length and content when looking at my own performance in order to determine a suitable booking interval. The dissolution of my partnership meant that my list size fell from 1650 (that is 3300 between two doctors) to 950 and as a result I was able to increase my appointment booking interval from 8.0 minutes to 10.0 minutes. I have carried out a study (unpublished) measuring durations and various aspects of the consultation before and after this decrease in list size and increase in booking interval.

The mean consultation duration rose from 9.0 to 10.2 minutes, with in both cases a range of 1-40 minutes.

Before the changes in list size and booking interval I showed that as the patient's consultation length increased there was a rise in: prescribing rate, number of problems dealt with, referral rate, amount of preventive activity, proportion of new pro-

blems, incidence of psychological and social problems and investigation rate. This finding was also true after the changes. Two possible hypotheses might fit these facts: the more complex the problem, the longer it takes and the higher the incidence of investigation, referral and prescribing; and/or when the consultation lasts longer, more complex problems are discovered and dealt with.

Comparing the data before and after the increase in booking interval and decrease in list size, it was noticeable that: the prescribing rate was identical (45% of consultations); the examination rate was identical (74% of consultations); the rates of single and multiple problems were almost identical; the total referral rate fell slightly, but probably not significantly, from 13.0% to 11.5%). This would support the hypothesis that for a given general practitioner in the same or similar population these variables are highly dependent on the doctor.

There were some differences, however, before and after: the proportion of consultations in which there were preventive care activities rose from 14% to 22% of consultations; the proportion of consultations in which current or chronic problems were reviewed increased from 34% to 50%; the proportion of consultations involving psychological and social problems increased from 13% to 19%. These three items are all areas in which I am extremely interested and this may have affected the patients' choice of which doctor to stay with. A doctor with different motivation might see different consequences from a fall in list size. However, if we feel that prevention, continuing care for chronic diseases, and offering more help for psychological and social problems are worthwhile aims, my experience would tend to support the claims that fall in average list size and increase in available consultation time would help achieve this.

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## No endocervical cells: an update

Sir,

Thanks to your publication of my letter on this subject (*January Journal*, p.40), I have now received some advice on the matter of endocervical cells which I wish to convey to other readers. A statement by the British Society for Clinical Cytology and the British Society for Colposcopy and Cervical Pathology dated June 1989 states:

'One of the factors determining the efficiency of the national programme for the prevention of cervical cancer is the quality of the smears. The best results in the detection of pre-cancerous changes in the cervix depend upon adequate sampling of the transformation zone.

'The transformation zone is the area of cervical mucosa originally lined by columnar epithelium in which metaplasia occurs, transforming the columnar cells into squamous epithelium. It lies adjacent to the squamous epithelium of the ectocervix at its external margin and adjacent to the columnar cells of the endocervix at its internal margin. Hence both metaplastic squamous cells and columnar cells will be derived from samples taken from this area.

'To the microscopist examining the smear the only indication that the transformation zone has been sampled is the presence of both of these types of cell. However, the presence of columnar cells is not sufficient evidence that the upper margin of the transformation zone has been sampled, and metaplastic cells are not always sufficiently distinctive to allow reliable identification under the microscope.' Thus states the report: 'It is unwise to rely on the presence of metaplastic cells or endocervical cells as evidence of sampling of the transformation zone.'

The assessment of the adequacy of a cervical smear thus remains subjective. Clearly there will be those smears which contain an insufficient quantity of epithelial cells and those samples in which the epithelial cells are obscured by blood or inflammatory cells, which will remain unsatisfactory and will need to be repeated. The laboratory should make it clear which smears these are. However, those smears which are otherwise quite satisfactory but do not contain endocervical cells can be recalled in the normal time interval. Although there is some suggestion that the chance of missing an epithelial abnormality is increased in smears without endocervical cells<sup>1</sup> there is also evidence that pre-invasive cancer can be detected just as efficiently from smears without endocervical cells.<sup>2,3</sup>

The onus therefore, quite justifiably rests with the person taking the smear. It is essential to be able to clearly visualize the cervix, take a good sample through 360 degrees and to transfer the sample to a slide and fix it properly. The medical defence bodies have also voiced their support of their members who adopt this approach.

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## Lyme disease

Sir,

Dr Nathwani and his colleagues have produced an excellent review of Lyme disease (*February Journal*, p.72). Their statement that the diagnosis is often missed by general practitioners is true, although it is our experience that it may also be overlooked by specialists in a variety of fields.<sup>1</sup> Once witnessed, the dramatic response of Lyme disease to antibiotics is never forgotten, and we now have a number of cases of clinical Lyme disease in our relatively small rural practice.

It is worth pointing out that endemic areas of Lyme disease in the UK may be much more widespread than was once thought, and that in such areas, the rate of seropositivity far exceeds the incidence of clinical disease. This complicates the interpretation of serology in symptomatic patients, especially when groups such as dairy farmers show a level of seropositivity of up to 15%.<sup>2</sup> We would entirely agree with Dr Nathwani and his colleagues that there should be increased awareness of this diagnosis by the public, general practitioners and specialists.

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## Age-band prevalence rates of long-term benzodiazepine users

Sir,

In a recent paper Simpson and colleagues (*January Journal*, p.22) identified a total