

university in October 1988. Of these, 122 (17%) had taken the leaflet. Leaflets were passed on by some students so that 168 (23%) in all had read it.

Testicular self examination had been performed at least once by 54/154 readers (35%) but by only 4/148 (3%) of non-readers. Only 19 students made a regular practice of testicular self examination. Significantly more (108/160, 68%) readers than non-readers (118/492, 24%) knew that the purpose of testicular self examination was to detect testicular cancer ($P < 0.001$, 95% confidence intervals for difference, 35.3% to 51.7%). Of 158 readers who gave an opinion as to the age at which testicular cancer occurs, 19 (12%) stated 15–40 years, which is the range given in the leaflet, and 110 (70%) gave ages within that range. Of 83 non-readers eight (10%) gave the 15–40 years range and 34 (41%) gave ages in that range. Readers also displayed some knowledge about the technique of testicular self examination, but there was no difference between the groups in knowledge of testicular cancer symptoms that are given in the leaflet.

There were 15 consultations at the student health service for scrotal complaints during the period of monitoring, seven following the first distribution of the leaflet, two after the second and six following the interviews. All but one took place within 10 days of the leaflet distribution or interview period. No testicular tumours were seen.

University students form an ideal group for education about testicular cancer because most of them are in the early part of the age range of greatest incidence. These results show that simply placing the testicular self examination leaflet to be collected is not an effective way of distributing it. The leaflet is an effective method of imparting information in that most of those who read it receive the important message that testicular abnormalities may indicate a curable cancer. The amount of detail recollected about the process of testicular self examination was, however, small.

The importance of information about testicular cancer in encouraging young men to perform testicular self examination was shown by Steffen.⁶ An argument against teaching potential patients about testicular cancer is the fear that primary care facilities would be overloaded with young men concerned about this disease.⁷ The present study and that of Vaz and colleagues⁸ have shown that this is groundless. However, there are valid questions to be raised about the amount of resources devoted to this exercise. A system which equips the patient himself to recognize the disease early and which costs little to administer is an economical

approach. The testicular self examination leaflet seems an appropriate option but it needs to be distributed in such a way as to ensure a high take-up rate. Further studies of this are in hand.

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Long to short consultation ratios

Sir,

Our practice would like to express its appreciation of the research on long and short consultations recently reported by Professor Howie and colleagues (February *Journal*, p.48).

I had the good fortune to hear Professor Howie's presentation of his group's preliminary findings at the 1990 Spring meeting of the Royal College of General Practitioners. Professor Howie demonstrated that, in consultation sessions with more than 12 patients, slow doctors performed less well and felt more stressed than faster doctors. We found that we were a practice of five 'slow' doctors and one 'intermediate' doctor. At that time our sessions involved seeing 16–18 patients, booked at 10 minute intervals, and it was quite usual to be running up to an hour late at the end.

We have now reorganized our appointment times so that each session is divided into two halves of eight or nine patients each, with an interval of at least 30

minutes in between. As a result, we are unanimously agreed that we are subjectively very much less stressed, we have time for a guilt-free cup of coffee and sessions running even 30 minutes late have become unusual.

We can vouch for the practical application of research findings.

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Sir,

Professor Howie and colleagues have published an article of interest to all general practitioners (February *Journal*, p.48), which has confirmed many peoples' assumption that the quality of consultations is affected by constraints on time.

His ultimate conclusion, that long to short term consultation ratios may be used to measure quality of care in the future does not, however, seem to be valid in the light of current trends within general practice.

Two of the three issues highlighted as being dealt with more effectively in 'long' consultations were long term health problems relevant to patient care, and health promotion. For many general practitioners both of these issues will be seen to be more appropriately dealt with in the health promotion clinics encouraged under the new contract, rather than in standard consultations. This introduces a new variable. When health promotion clinics are used this will be reflected in fewer 'long' consultations and thus a fall in the long to short consultation ratio for both 'faster' and 'slower' doctors. This would not necessarily indicate a fall in quality of care, indeed many would argue that quality of care of long term health problems, for example, diabetes, asthma and hypertension, is improved in the health promotion clinic setting.

It is likely that although the standard surgery consultation length may fall in these patients, total time spent with them may increase. This will not necessarily be followed by an increase in patient satisfaction as patients may not be happy about attending a variety of separate clinics on separate occasions.

The effect of health promotion clinics on consultation time is not predictable either, with some general practitioners claiming to run 20–25 per week while my own experience in an eight partner practice is of considerably less.

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