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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Osteopathy in general practice

Sir,
As an osteopath and a general practitioner we are writing to report an outcome study of osteopathic services in one general practice.

Leyton Green Neighbourhood Health Service is a collective general practice in east London. It provides care for a mixed urban population of 4000 patients. Since 1989, osteopathy has been an integral and free part of the services offered.

A study was undertaken to look at changes in patients' outcome measures associated with osteopathic treatment. Medical notes were compared for the year before starting osteopathic treatment with the notes one year after completing treatment. The number of consultations for all problems, and medication prescribed likely to be related to osteopathic problems (analgesics, tranquillizers and hypnotics) were examined. The number of days' treatment at full dosage represented by each prescription was estimated, for example, 80 paracetamol tablets represented 10 days' medication. Since the parameters were not normally distributed the difference between 'before' and 'after' was tested using a two sample rank test (Mann-Whitney-Wilcoxon test).

Sixty one patients had completed their treatment between 1 March 1991 and 1 September 1991. However, 10 patients had to be excluded because their notes had been lost, they had left the practice, died, or were too young to have one year's pre-treatment notes. This left a sample of 51 patients.

Consultations in the year before osteopathic treatment ranged from 0 to 29 with a mean of 7.5 consultations. In the year after treatment, they ranged from 0 to 15 with a mean of 4.8 consultations. The mean number of consultations after treatment was therefore 64% of the pre-treatment level (Mann-Whitney test $P < 0.01$).

Prescriptions for analgesics, hypnotics and tranquillizers in the year before treatment ranged from 0 to 231 days' medication, with a mean of 42.7 days. In the year after treatment, the range was from 0 to

255 days' medication, with a mean of 24.9 days. The mean number of days of medication after treatment was 58% of pre-treatment levels (Mann-Whitney test $P < 0.001$).

This study has shown osteopathic treatment in a self-selected population to be associated with a reduced consultation rate and a reduction in the number of days of medication prescribed.

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Consultations for minor problems

Sir,
At times I find myself regarding consultations for minor, self-limiting illnesses as an inappropriate use of medical skills which also diminish people's self reliance, so I encourage people to cope on their own with these problems in the future. At other times I am aware of the many positive potentials in this type of consultation¹ and am pleased that people attend with these complaints.

In order to explore these contradictory attitudes, I undertook a study while working at Cromwell Place Surgery, St Ives. A questionnaire was sent to every second general practitioner on the Cambridgeshire Family Health Services Authority list.

A total of 182 possible respondents received the questionnaire and 158 replies were returned, a response rate of 86.8%.

With regard to a consultation for an uncomplicated upper respiratory tract infection, 94.9% of respondents stated that they usually gave advice and encouragement as to how patients could cope on their own with similar complaints in the future. Eighty seven respondents (55.1%) said they thought patients consulting for this complaint lacked self reliance, and 32.3% felt that their management contributed significantly to alleviating the presenting symptoms.

Furthermore, 55.7% of respondents indicated they usually spent time on other ongoing problems the patient may have had, 65.2% usually focused on other unrelated aspects of health promotion, and 50.6% usually regarded this type of consultation as an important opportunity to build rapport with their patients.

Almost 80% of respondents (126) thought they usually used time saved by this potentially short consultation to devote to patients with more demanding complaints; 46.8% usually regarded a consultation for an upper respiratory tract infection as a welcome break in what might otherwise be a continuously stressful surgery.

Thus, almost all of the general practitioners in this survey believed they tried to modify help seeking behaviour in patients with an uncomplicated upper respiratory tract infection, and many found other aspects of this consultation to be valuable. If people did not attend for this sort of condition, how would this affect rapport building, management of other ongoing problems, opportunistic health promotion, screening, and doctor's time and stress management? As doctors seek to change people's help seeking behaviour, both at the individual and public level, they should also evaluate the importance of the losses that their possible success implies.

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Alcohol and the GP contract

Sir,
I was interested to read the study comparing the health and lifestyle of general practitioners and teachers (September *Journal*, p.378). I conducted a similar sur-

vey among general practitioners registered with a local family health services authority in Calderdale, West Yorkshire. Because the survey involved general practitioners in Yorkshire, it allows comparison with Chambers and Belchers' study in Staffordshire. It is also instructive to compare the figures found in Calderdale with Office of Population Censuses and Surveys data.¹

Chambers and Belcher achieved a 48% response rate in 1989 and an 82% response rate in 1991. Response rates to the postal questionnaires in Calderdale were 74.5% of 94 general practitioners in May 1988 and 74.8% of 107 in May 1991. The sex distribution of all 107 doctors in 1991 (81.3% men) was practically identical to that of the respondents to their study (81.2%).

The general practitioners in Calderdale were divided into groups according to the amount of alcohol they reported drinking in the sample week. In 1988, 14.3% of the 70 general practitioners responding reported that they did not drink alcohol, 51.4% drank between one and 10 units, 32.9% drank between 11 and 50 units and 1.4% drank more than 50 units in the sample week. In 1991, 17.5% of 80 respondents reported that they did not drink alcohol, 45.0% drank between one and 10 units, 36.3% drank between 11 and 50 units and 1.3% drank more than 50 units in the sample week. Office of Population Censuses and Surveys data for professionals (with the same proportion of men: women as in the Calderdale study in 1991) are 25.7%, 37.7%, 31.6% and 4.9%, respectively.¹

The number of units of alcohol consumed each week by the Yorkshire general practitioners compared with the Staffordshire doctors is shown in Table 1.

In May 1988 the mean consumption in the sample week was 10.9 units. In May 1991 this was 9.6 units. In 1988 the mean number of days on which alcohol was consumed was 3.4 days (95% confidence interval (CI) 2.9 to 3.9 days) and in 1991 3.1 days (95% CI 2.6 to 3.6 days). This difference was not significant.

Hannay and colleagues found that the 1990 contract for general practitioners had significantly increased the general med-

ical services work done by general practitioners.^{2,3} Previous work has implicated stress as a factor related to increased alcohol consumption among doctors.⁴ Sutherland and Cooper found that general practitioners experienced more stress, less job satisfaction and poorer mental health in 1990 than in 1987.⁵

Whether or not the new contract caused an increase in stress, there does not appear to be any evidence that it was associated with any discernible increase in the alcohol consumption of Staffordshire or West Yorkshire general practitioners.

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Cervical smears

Sir,

We were interested to read the paper by Buntinx and colleagues investigating whether feedback improved the quality of cervical smears taken by doctors.¹ The method of this study is similar to one we are currently implementing using a commercial cytology laboratory serving over 200 practices and more than 400 physicians and nurse practitioners. We have previously used monthly feedback on cervical smear performance to improve the quality of smears in a trainee programme.^{2,3} There are several comments we would like to make regarding the study by Buntinx and colleagues.

The collection of data from subjects (that is, doctors) without their permission

or knowledge is not allowed in the United States of America. Informed consent is required both to participate in and to publish the data. We presume this is not the case in Belgium, which makes the recruitment of subjects for research much easier and cheaper. There might be another issue to consider in the event that a diagnosis of cervical cancer is missed on the cervical smear. It is possible that the doctor involved could be identified in the study as a poor performer and this information might be used in litigation by the plaintiff.

The authors specify definitions and criteria for adequacy of cervical smears, but it is not clear how these were used to assign them to categories of excellent, moderate or unsatisfactory. Are the categories the same as or equivalent to national or international standards of adequacy? For example, in the USA, five endocervical cells are the minimum number for an adequacy criterion, whereas no figure was given in the paper by Buntinx and colleagues. Finally, it would be interesting to know whether validation procedures were applied to the cytotechnologists to assess the reliability of their ratings of adequacy.

It was surprising that no mention was made of cervical smears taken from menopausal women or from those who had had hysterectomies. In our current study (not yet published), 5.5% of smears from this group of women showed significant atrophy. The distribution of these smears among participating doctors might well not be uniform, depending on their practice populations, and this could bias adequacy rates of smears and detection rates of pathological cells.

Although there was a decrease in the number of smears without endocervical cells and an increase in the identification of pathological cells within the group of doctors receiving feedback the authors do not comment on the fact that the control group also showed substantial improvement in adequacy rates. This suggests that the control physicians were, in fact, aware of the study or had been influenced by the information pack sent to all doctors. The control group performed better than one of the intervention groups on certain criteria, such as intervention quotient for slide fixation.

The authors comment on the simplicity and low cost of a feedback system which makes it an attractive intervention. This may be true in a well organized health care system with standardized laboratory procedures and information systems. In the USA, with commercial and public health laboratories vying for customers, doctors and practices change laboratories quite frequently depending on service and

Table 1. Units of alcohol consumed each week by doctors in Staffordshire and Calderdale, Yorkshire in 1991.

GPs in:	% of GPs consuming units of alcohol in one week				
	0	1-7	8-14	15-21	22+
Staffordshire (n = 693)	19.3	42.6	19.2	10.0	8.9
Yorkshire (n = 80)	17.5	36.3	25.0	7.5	13.8

n = number of GPs in group.