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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.

Community-acquired infections

Sir,
Prescribing in primary care is currently under pressure and antibiotic prescribing is one area in which concern has been expressed at the use of expensive newer agents.¹ Respiratory and urinary tract infections are the commonest reasons for prescribing antibiotics for the elderly population and also common causes of referral to hospital.² Most patients referred with an infection have previously been treated with antibiotics and reasons for referral are commonly the severity of illness or failure to improve on treatment, the latter raising concern about possible resistant bacterial infection.

On the basis that an appreciable level of resistant bacterial infection would be reflected in positive blood cultures on admission to hospital, a six month retrospective study was undertaken of patients with infection admitted to the geriatric unit of a district general hospital. Results of blood cultures were examined to ascertain the prevalence of positive blood cultures, and whether the organisms isolated and their sensitivities resulted in a change of antibiotic treatment from that instituted on admission.

Over the six month period between January and June in 1992 385 blood cultures were performed on 289 patients (approximately 25% of all admissions for any reason in that period). Blood cultures were performed where infection was suspected and where the patient was considered very unwell. Blood cultures were positive in 38 patients but only in seven were the results thought to be clinically significant by the reporting microbiologist, the rest either being thought contaminants or of uncertain significance. Organisms isolated in these seven patients were *Escherichia coli* (three), *klebsiella* (two), *proteus* (one), and *Staphylococcus aureus* (one). In three of the seven patients microbiology findings resulted in changes in therapy.

The prevalence of clinically significant blood cultures in patients admitted from the community was not high at 2.4%, but compares with that reported in other studies.^{3,4} The low prevalence may well reflect

previous antibacterial therapy received in the community; most of the 289 patients admitted had either received amoxycillin or trimethoprim. The organisms identified in positive blood cultures were in fact more typical of hospital acquired infections.²

It therefore seems that antibiotic treatment of community-acquired infections with standard regimens is appropriate for most chest and urinary infections, at least in this district. Reasons for admission of patients to hospital after being treated for infection appear to have been more related to associated clinical problems in elderly people, as evidenced from the patients' notes, such as dehydration, bronchospasm, hypoxia, heart failure, and difficulty in coping when unwell and living alone, than to resistance of infection to standard antibiotic regimens.⁵ There does not, therefore, seem to be a major need for more powerful broad-spectrum antibiotics as first-line treatment of community-derived infections in primary care.

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Cervical screening

Sir,
It is mandatory in England for general practitioners to invite individuals for health screening.¹ It is therefore important that general practitioners should be aware of how their patients feel about the proced-

ures involved, and that the clinics they hold should be organized to be as effective as possible in detecting risk factors and early manifestations of disease. As a gynaecologist I have a particular interest in community based gynaecological screening in terms of acceptability for the woman and the usefulness of the screening test.

It has been suggested that the majority of women feel some degree of embarrassment and discomfort when undergoing a gynaecological examination but the range of their feelings is considerable with extreme discomfort and hostility toward the medical personnel being reported.² A later study into patients' attitudes indicated that women saw the examination as a necessary and reassuring procedure and because of this learned to deal with their negative feelings well enough to allow proper gynaecological examination with a minimum of overall discomfort.³ This apparent improvement in emotional response to a pelvic examination may reflect the greater emancipation and increasing recognition of female sexuality that occurred during the 10 year period between the two studies. It may also reflect changing attitudes of doctors towards their patients, or perhaps may indicate better patient education with its associated alleviation of fear.

The importance of cervical screening in the prevention of cervical carcinoma is indisputable and it is now becoming more common for the cervical smear to be taken by the practice nurse. One advantage of this is that it gives the woman a better opportunity of having a potentially threatening and embarrassing test performed by another woman. However, if the smear is taken by the nurse a bimanual pelvic examination is omitted. This does not matter provided that the frequency of asymptomatic, palpable pelvic pathology in this population group is rare.

In order to assess women's attitudes to a bimanual examination 168 women undergoing routine cervical screening in one general practice had pelvic ultrasonography performed, and completed an attitude questionnaire. Two cases of pelvic pathology were identified using ultrasound that would have been detected by a careful clinical examination. The first was

a six-week intrauterine pregnancy and the second an asymptomatic ovarian cyst (7 cm diameter). Using a visual analogue scale to record the degree of discomfort caused by screening procedures, a bimanual vaginal examination did not cause more distress than breast examination or venesection. Ninety four per cent of women felt that a vaginal examination reassured them that all was well and 94.6% felt that it should be performed routinely, although 22.6% felt that it might put other women off attending.

In conclusion, it would appear that these women felt reassured that they had a healthy pelvis if a vaginal examination was performed at the same time as a cervical smear. As a group they were not unduly distressed by the examination and, as pathology may be detected, the opportunity to examine the pelvis digitally at cervical screening should not be missed. Either general practitioners should resume the practice of smear taking and combine this with a bimanual examination, or nurses responsible for cervical screening should be trained in performing the additional examination.

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Alternative contracts in the NHS

Sir,
A letter from Julian Tudor Hart¹ quotes from an article by Professor Maynard, Dr Marinker and me, published in the *British Medical Journal* in 1986, about the possibility of alternative contracts in the National Health Service.² Unfortunately, Tudor Hart has misrepresented the sense of that paper.

First, in terms of historical accuracy, it was Enthoven who first proposed a market approach.³ His monograph was published the year before our article and we as professionals were examining what was then a new idea. The article to which Tudor Hart refers was the third in a series and its title raised as a question whether alternative contracts were viable.

In the first paragraph the exact words

were: 'Here we examine five further options.' This makes it clear that the authors were in no way at that time advocating a managed NHS market; on the contrary, our exact words were: 'We conclude that the development of a good practice allowance, along the lines described in our previous paper⁴ represents the best choice at this time for the public, the government, and the profession.' Furthermore we repeated this point in the final paragraph headed 'What option?': The opportunity exists to reform the present contract by adopting some variant of our own interpretation of the government's desire for a good practice allowance.

'It is not impossible that a system similar to HMOs [health maintenance organizations] may become the pattern for a future national health service. Implementing a good practice allowance now would give us invaluable experience in setting standards for primary health care, monitoring performance, and reviewing and maintaining progress. If this does not happen it is likely that some stronger and more radical medicine will be administered to the system of general practice in the UK.'

In hindsight it now seems clear that had the profession felt able to accept a good practice allowance which the Royal College of General Practitioners had proposed in 1985⁵ and the government had offered the profession in 1986,⁶ it would inevitably have had to be negotiated with the representatives of general practice. This would have been a more professional arrangement than the subsequent contract, which was imposed on the profession in 1990 and indeed formed the 'stronger and more radical medicine' which we feared in 1986.

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Patient involvement in medical education

Sir,

Jones and Oswald conclude that patients' attitudes are unlikely to present an appreciable barrier to increased medical student learning in general practice (letters, April *Journal*, p.184).

Patients in a recent qualitative study undertaken in our department were enthusiastic about involvement in medical education and some believed they could play a more active role, particularly in improving students' communication skills. All of the 26 patients interviewed expressed a willingness to take part in consultations where a student was present. A subsequent questionnaire study based on our results, carried out by medical students with 180 patients in Leeds confirmed our results (unpublished results). Both studies showed that patients perceive benefits for themselves and have few reservations.

Patients perceived the advantages of having a student present in the consultation as: helping to educate future doctors; learning more about their condition from the discussion between doctor and student; receiving a more thorough check up; interest in seeing the students' approach; and having someone uninvolved in their care to talk to (particularly if students visit patients at home). They saw the disadvantages as: potential embarrassment if the patient has a personal problem; feeling uncomfortable at being watched by the student; upsetting if the student appears uninterested; and the consultation may take longer.

Older patients (mostly those who had retired) in particular were enthusiastic about a more active involvement in student education. They had strong views about what students should learn, feeling that good listening, questioning and explaining skills were of paramount importance, along with the right attitude towards the patient (kind, respectful, not patronizing). This suggests that patients, in common with other potential community teachers,¹ would like a say in the sort of doctor that medical schools produce.

Thus, potential teachers, including health visitors, general practitioners, nurses and complementary practitioners would need to be involved in developing a curriculum which reflected the priorities, needs and ethos of primary care, rather than being expected to teach topics simply 'transferred' from the hospital. Realizing the potential for patient involvement in medical education clearly requires further work to identify the range of issues patients wish to see addressed, and appropriate teaching and learning methods.