

appropriate treatment and contact action, thereby reducing the potential for serious secondary complications.

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## Reducing stress among practice staff

Sir,  
Most general practitioners would recognize the picture of a practice working to capacity, leading to high levels of staff stress. These stresses are sometimes seen as part of the job. However, our experiences, as a psychiatrist and a psychologist suggest that, while some strain is inevitable, unquestioning acceptance of stress is unhelpful.

The practice manager and the general practitioners in one inner city health centre identified high levels of stress in their practice nurses and receptionists, and asked us to offer support and training. This took the form of separate sessions for the receptionists and nurses, held without the practice manager or general practitioners. In both cases, an initial meeting of one hour was followed up by a two hour training session.

The receptionists revealed profound dissatisfaction with their job, feeling that they were looked down upon both by their professional colleagues and by patients, and that they were caught between the demands of patients and busy general practitioners. They had few effective techniques for dealing with their predicament — usually they managed by making them-

selves 'look helpless,' 'subservient' or 'childlike' which, while successful, also placed them in an inferior position, leading to further demoralization and a sense of disempowerment.

The practice nurses complained that they were overwhelmed by the demands of patients, rarely leaving the practice on schedule, unable to take breaks and having no time for further training. As a consequence they felt they lacked the skills needed to perform their jobs, were professionally isolated, unsure where they fitted in the practice structure and trapped into a cycle in which, although aware of their needs and deficiencies, they were unsure how to effect change. The increasing gap between their real and their ideal job led to further demoralization and less capacity for change.

In both cases low morale and the pressure of work, combined with a sense of having little control over working practices, led to a sense of helplessness and further demoralization. Discussion of these issues — and particularly identification of ways in which they could adopt different strategies to effect change — led to modifications in behaviour and reorganization of practice procedures. Largely this reflected the fact that nurses and receptionists were able to say what they needed to do their job more effectively. We prepared a formal report on our interventions which the practice manager and general practitioners used to make the management changes required. A number of improvements followed in the three months following the intervention, the practice manager reporting that absenteeism and sickness rates had reduced markedly, and that the receptionists and nurses were working more efficiently and effectively.

It appears that relatively small amounts of professional input (in this case up to eight hours in total) can lead to staff experiencing major changes in their self-worth, and consequently in their ability to contribute to the work of the practice. One explanation may be that the intervention enabled staff to consider their position within the multidisciplinary team, and that managers were able (and willing) to use the feedback they received to make changes themselves. Systemic theory teaches us that relatively small shifts in one part of the system can have a disproportionate effect on the system as a whole, setting in motion major change.

We would encourage other practices to consider establishing regular consultation sessions for different staff members. These should not be for a complaint, but as occasions for staff to articulate their problems in a safe environment, and to

reframe negative criticism into constructive solutions. The process becomes one of empowerment, by redefining staff as experts in their own jobs, and themselves as the agents able to implement their own solutions. A full report of this intervention is available from the authors.

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## Patients' awareness of diagnosis

Sir,

It is common practice in hospices to have a sheet of paper in patients' notes on which is recorded what patients have been told or what they have said about their illness. I have successfully introduced such a sheet into the records of patients with malignancies in our practice.

The sheet consists of an ordinary continuation card (FP7) with a label stuck at the top on which is printed 'Patient's awareness of diagnosis', with space below for the diagnosis to be written. The rest of the card can be used for comments about what has been said to the patient by the general practitioner and hospital doctor (taken from hospital letters), and remarks made by the patient. The outer envelope of the notes is flagged with an adhesive blue circle which alerts the doctor to a malignancy, and hence the presence of the extra card. When the opportunity arises, I ask patients what they know about their illness and write the reply on the card.

Over a five month period I discovered 134 patients with malignant disease in our practice population of 8000. At the outset I read all the general practitioner notes and hospital letters and found that 73 (54%) had information about what patients knew of their illness, but in only two cases was this information readily accessible. Five months after introducing the new card, these figures had increased to 105 (78%) and 105 (78%), respectively.

Each doctor will have about 40 patients on his or her list with a malignancy.<sup>1</sup> Enthusiasts could undertake the task of searching on their computer for all patients with malignancy and putting