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 themselves '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.[1] Enthusiasts could undertake the task of searching on their computer for all patients with malignancy and putting

cards in the notes, or cards could be added opportunistically as patients are seen. Past hospital letters could be read to glean this information, but only 9% of letters about patients with cancer inform general practitioners unequivocally what patients have been told about their diagnosis.[2]

The cost and work involved in adding this new card is minimal, but the benefits are considerable. They inform the consulting doctor what the patient knows about the illness. This is particularly useful for a trainee or locum, or a partner who normally does not see the patient. The doctor can also use the information when referring to a hospital colleague or other member of the primary health care team.

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Practice guidelines and practical judgement

Sir,
I appreciated Bruce Charlton's wise editorial on guidelines and practical judgement (July *Journal,* p.290). Although considering myself a guidelines enthusiast, I too am concerned about the undervaluing of tacit knowledge as well as our current inability to incorporate the results of qualitative research into clinical guidelines. The challenge of applying the results of clinical trials to individual patients is dwarfed by the epistemological problems of putting into practice insights from qualitative studies. For example, a coronary heart disease management guideline which bases recommendations solely on randomized controlled trials would exclude knowledge about the experiences and needs of patients after a myocardial infarction.[1] Can this type of knowledge contribute to recommendations in guidelines? What relationship does it have to recommendations derived from randomized controlled trials about, for instance, the beneficial effects of low dose aspirin?

On another point, I would question the closing sentence of the editorial: 'Good guidelines depend upon pre-existing good practice; guidelines are not the cause of good practice.' If one has a general concept of good practice as some form of absolute state, the statement is a tautology: doctors can only be good doctors if they are already good doctors. If, in fact, good practice can coexist with bad practice for the same clinician, which is certainly my personal experience, then there is no intrinsic reason why guidelines based on evidence-based good practice cannot make my clinical practice better. Indeed, there is evidence from a wide range of settings that guidelines with a dissemination/implementation strategy can do just that.[2] Initial results from research in east London confirm that this is also the case in inner city general practice (Feder G, *et al.* Association of University Departments of General Practice annual scientific meeting, 13-15 July 1994).

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Assessing inhaler fullness

Sir,
We were pleased to see the study by Rickenbach and Julious highlighting the problem of patients being unable to assess the contents of metered dose inhalers accurately (July *Journal,* p.317).

In our study into this problem, three of 51 subjects had been trained to float their metered dose inhalers in order to assess the contents.[1] However, when given a nearly empty inhaler to assess, they did not ask to float the canister, instead they shook it and listened to it in the same way as the remaining subjects. There is nothing on the canister to inform patients at what stage to try the floatation technique. If patients are advised to try this method when they judge their inhalers to be nearly empty, it is no longer an objective technique.

As patients are unable to assess the contents of their inhalers objectively, they regularly run out of medication.[1] In our opinion this design flaw is associated with morbidity and mortality from asthma. It is essential that metered dose inhalers should have a dose counter fitted before they are considered to be a safe delivery system.

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Referral for x-ray

Sir,
Neal emphasizes the benefits of the therapeutic x-ray in reassuring patients (September *Journal,* p.427). His comments are well founded. A study of 530 general practitioner radiology referrals showed that 7% were done solely to reassure the patient.[1] Pressure from patients seems to be the third most common reason for general practitioner requests for sinus radiology.[2] Furthermore, a survey published in this *Journal* found that 88% of general practitioners requested radiographs to reassure patients: 'Faced with a vociferous, complaining patient a general practitioner may adopt a pragmatic approach.'[3]

However, many of the Royal College of Radiologists' guidelines[4] are based on formal studies and would have medico-legal backing. Unnecessary x-rays statistically cause over 100 deaths each year from malignancies.[5] Whether or not patients are referred for radiology, general practitioners should explain clearly when clinical examination and guidelines suggest that radiology is not indicated.

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