

# Influence of sex of general practitioner on management of menorrhagia

ANGELA COULTER

VIV PETO

HELEN DOLL

## SUMMARY

**Background.** There is an assumption that men and women general practitioners adopt different practice styles in the management of gynaecological disorders. However, there is little evidence to support this view.

**Aim.** A study was undertaken to compare the practice styles of men and women general practitioners in the management of menorrhagia.

**Method.** The study took place in 73 general practices in the Oxford Regional Health Authority area. A total of 348 patients who consulted 74 men general practitioners and 43 women general practitioners with a complaint of menorrhagia were recruited into the study and completed postal questionnaires nine and 18 months after entry into the study. Main outcome measures were men and women general practitioners' awareness of patients' treatment preferences, treatment received by patients, patients' involvement in treatment decisions and patients' satisfaction with treatment received.

**Results.** There were no statistically significant differences in treatment received by patients of men and women general practitioners. Fewer patients consulting women general practitioners were referred to a gynaecologist compared with patients consulting men general practitioners (56% versus 64%) and fewer underwent surgery (39% versus 47%). More patients consulting women general practitioners reported participation in treatment decisions (63% versus 53%) but more patients consulting men general practitioners were satisfied with the care they received (66% versus 55%). Again, these differences were not statistically significant.

**Conclusion.** Although some indications of sex-associated differences in practice style were found in this study, the similarities in practice styles of men and women general practitioners were more striking than the differences.

**Keywords:** menorrhagia; management of disease; doctors' sex; sex influenced behaviour; doctors' attitude.

## Introduction

THE opportunity to consult a doctor of either sex is becoming more common in British general practice where women gen-

eral practitioners now constitute 27% of the total in England.<sup>1</sup> It is well known that many women prefer to consult a woman doctor for gynaecological problems when given a choice.<sup>2-13</sup> Patients' reasons for this preference include the feeling that a woman general practitioner will be easier to talk to about embarrassing problems, that she is more likely to show understanding and empathy, that she will be more knowledgeable and experienced in the management of gynaecological problems, and that she will be less likely to medicalize the problem unnecessarily. In other words, there is an assumption that men and women general practitioners adopt different practice styles in the management of gynaecological disorders.

Research evidence in support of this view is scarce. In a study from the Netherlands, van den Brink-Muinen and colleagues found few differences in the treatment of women's health problems by men and women general practitioners, although men were more likely to offer medication or referral for menstrual problems.<sup>13</sup> A Norwegian study of practice patterns in the management of women's urinary incontinence found some sex differences in general practitioners' management but these were small.<sup>14</sup> In a study of variations in hysterectomy rates between eight districts in Oxford Regional Health Authority, Coulter and colleagues found that the district with the lowest hysterectomy rate — nearly half that of the district with the highest rate — had twice as many women general practitioners, suggesting the possibility that women general practitioners had lower gynaecology referral rates than men general practitioners.<sup>15</sup> A number of studies have found that, compared with men general practitioners, women general practitioners achieve higher cervical smear uptake rates<sup>16-18</sup> and this may be in part because they have better understanding of patients' feelings about pelvic examinations.<sup>19</sup>

A prospective study of the management of menorrhagia in general practice offered an opportunity to compare the practice styles of men and women general practitioners in relation to this common gynaecological problem. Menorrhagia can be treated either medically or surgically. Around 800 000 prescriptions for drugs to reduce menstrual blood loss were issued in England and Wales in 1993 at an estimated cost of seven million pounds (Intercontinental Medical Statistics Limited, 1994). Menorrhagia is one of the most common conditions referred to gynaecology outpatient clinics, accounting for 12% of all referrals<sup>20</sup> and is the main presenting problem in at least half of all hysterectomies.<sup>15,21</sup> There are wide variations in referral rates and surgical rates indicating a lack of consensus among general practitioners and gynaecologists about when surgical rather than drug treatment is indicated for this condition and vice versa.<sup>22</sup>

In view of the known geographical variations in practice management and referral patterns, it seemed possible that there would also be differences in the way in which men and women general practitioners manage menorrhagia. A study was undertaken to test the following hypotheses: that women general practitioners would be more aware of their patients' preferences than men general practitioners, that they would adopt a more participatory decision-making style, that they would be more likely to recommend non-invasive investigations and treatments and be less willing to refer their patients for surgery, and that patients cared for by women general practitioners would be more satisfied with their treatment than patients cared for by men general practitioners.

A Coulter, MSc, director, King's Fund Centre for Health Services Development, London and visiting professor in primary health care, University College London Medical School. V Peto, BA, research officer and H Doll, MSc, statistician, Health Services Research Unit, Department of Public Health and Primary Care, University of Oxford.  
Submitted: 20 September 1994; accepted: 2 February 1995.

© British Journal of General Practice, 1995, 45, 471-475.

## Method

### Recruitment

A total of 129 general practitioners in 73 practices in the Oxford Regional Health Authority area recruited patients consulting with a complaint of heavy menstrual bleeding. Of the general practitioners 79 were men and 50 were women. Recruitment involved telling the patient about the study and handing her an information sheet and a questionnaire, to be completed later in her own time. Those eligible for entry to the study included all women in the age group 30–49 years who consulted with a first or subsequent complaint of heavy menstrual bleeding, regardless of severity of symptoms and regardless of whether the condition was reported by the patient or diagnosed by the doctor. This initial consultation was the index consultation. All women who returned completed questionnaires were entered into the study and sent two further questionnaires, the first after nine months and the second after 18 months. Management of individual patients was decided by general practitioners and specialists in the usual way and treatment choice was unaffected by entry to this observational study. A validation study and some other findings from the study have been published elsewhere.<sup>23–25</sup>

### Patients' questionnaires

The patients' questionnaires asked about reasons for consultation (first questionnaire only), treatment preferences, current symptoms and previous medical history (including number of general practitioner consultations in the previous 12 months, previous experience of surgical operations for any conditions and for gynaecological conditions, and number of previous consultations for this episode of menorrhagia), involvement in decision making, treatment received and, on the first and second questionnaire only, demographic details and socioeconomic status. Social class was classified according to the registrar general's scale<sup>26</sup> based on the woman's own current or most recent occupation. The third questionnaire also included questions about satisfaction with treatment received, which respondents were asked to rank on a five-point scale ranging from very satisfied to very dissatisfied.

A menstrual symptom score was derived from answers to questions about duration of menstrual periods, number of sanitary pads and tampons used, experience of flooding and passing blood clots, frequency of bloodstaining on clothes, and extent of dysmenorrhoea. Responses to the frequency scales were summed, with a possible score range of between zero and 23. The social impact score consisted of responses to a series of questions about the extent to which menstrual period problems interfered with different aspects of the woman's life, including emotional state, paid employment, domestic work, family relationships, sexual activity, social life, leisure activity and holidays. Total possible scores on this scale ranged between zero and 40. Scores on both scales were calculated as a percentage of the maximum, with 100% representing the worst possible experience. For each scale responses were grouped into three, with scores in the range 0%–33.3% classified as mild, 33.4%–66.6% as moderate and 66.7%–100% as severe.

### General practitioners' questionnaire

General practitioners were asked to complete a simple one-page form after the index consultation for each patient recruited, giving details of their view of the severity of the problem (on a nine-point scale ranging from mild to severe), whether or not related signs and symptoms were present (for example, intermenstrual bleeding, postcoital bleeding, dysmenorrhoea, fibroids, anaemia, premenstrual tension, tiredness, depression and stress), their understanding of the patient's treatment preference and their prediction of the likely treatment.

### Statistical analysis

The data were entered onto a computer and analysed using SPSSPC. The chi square test was used to test for differences in proportions and its  $\chi^2$  component to test for linear trend. The Student's *t*-test was used to test for differences in means and the Mann Whitney *U* test was used if the data were non-normally distributed. Since there were age and social class differences between the patients consulting men general practitioners and those consulting women general practitioners, the analyses were repeated adjusting for age and for age at completion of full-time formal education (chosen as the best representation of social class) in logistic regression models. The *P* values given are those from the adjusted analyses. Two-tailed tests of significance were used in all cases.

## Results

The general practitioners recruited 518 patients during the 15-month recruitment period in 1990–91. Thirty five patients were excluded because they were outside the specified age range, leaving 483 eligible patients, of whom 425 (88.0%) returned completed questionnaires and were entered into the study. This paper reports the findings from the 348 out of the 425 patients (81.9%) who returned both the two follow-up questionnaires. Between them, these patients had consulted 117 general practitioners. A total of 177 patients consulted 74 men general practitioners and 171 patients consulted 43 women general practitioners.

### Sociodemographic characteristics, symptom severity and past medical history

There were some significant differences in the sociodemographic characteristics of the patients who consulted men and women general practitioners (Table 1). In particular, those consulting women general practitioners were of higher social status according to both the registrar general's social class ( $\chi^2 = 6.33$ ) and age at completion of full-time formal education ( $\chi^2 = 13.24$ ). Since the latter had the strongest association with the dependent variable, it was included with age in the regression model.

There were no significant differences (before or after adjustment) between the two groups of patients on any of the measures of symptom severity or past medical history (Table 2).

### Treatment prediction and patient preference

General practitioners' predictions of the likely treatment based on their assessments following the index consultation and the patients' preferences are shown in Table 3. In total, the general practitioners predicted that 140 of 341 patients (41.1%) would eventually have surgical treatment for menorrhagia. There was no evidence that men general practitioners were more likely to predict a surgical outcome than women general practitioners; both groups of general practitioners made similar initial predictions.

Only 129 patients (37.1%) indicated that they had a strong treatment preference following the index consultation (Table 3). Eighteen months after the index consultation the number of women who reported having developed a strong preference had increased to 187 patients (53.7% of the total). The preference for surgical treatment increased from 14.4% of the total number of women to 32.5% and this preference was more pronounced among patients consulting men general practitioners. Patients consulting women general practitioners were more likely to express an initial preference (after the index consultation) for minimal treatment compared with those consulting men general

**Table 1.** Sociodemographic characteristics of patients, by sex of general practitioner consulted.

Characteristic	% of women consulting	
	Man GP (n = 177)	Woman GP (n = 171)
<i>Age group (years)*</i>		
30–34	16.9	7.6
35–39	19.8	31.0
40–44	36.7	35.7
45–49	26.6	25.7
<i>Marital status<sup>a</sup></i>		
Married	87.0	87.6
Divorced/separated	10.7	9.5
Never married	2.3	3.0
<i>Social class<sup>b,**</sup></i>		
1, 2	23.9	39.8
3N, 3M	54.0	42.2
4, 5	22.1	18.0
<i>Age at completion of full-time education (years)***</i>		
≤16	61.6	48.5
17/18	26.0	20.5
19+	12.4	31.0
<i>Employment status</i>		
Employed full time	38.4	37.4
Employed part time	42.9	45.0
No paid employment	18.6	17.5

*n* = number of women patients in group. <sup>a</sup>Data missing for 2 women consulting women GPs so *n* = 169. <sup>b</sup>Data missing for 14 women consulting men GPs so *n* = 163, and data missing for 10 women consulting women GPs so *n* = 161. <sup>c</sup>*χ*<sup>2</sup> test for trend: \**P*<0.05, \*\**P*<0.01, \*\*\**P*<0.001.

practitioners (*P*<0.05), but this difference had diminished by the time of the third questionnaire. More men general practitioners than women general practitioners believed that their patients had no preference for treatment, but more of their assessments of their patients' preferences following the index consultation were accurate compared with those of the women general practitioners.

#### Treatment received

Nearly all patients received a course of drug therapy for their menorrhagia, this being slightly more common among patients consulting men general practitioners (Table 4). There were no significant differences between the two groups in the proportion having dilatation and curettage or other diagnostic investigations. A total of 209 patients (60.1%) were referred to a gynaecologist and 151 (43.4%) underwent surgical treatment for menorrhagia (hysterectomy or endometrial resection) or were on the waiting list for surgery. Two women in each group had both endometrial resection and hysterectomy. Fewer patients consulting women general practitioners were referred compared with patients consulting men general practitioners (56.1% versus 63.8%) and fewer underwent or were waiting for surgery (39.2% versus 47.5%) but these differences were not statistically significant.

The majority of patients who expressed a preference had received the treatment they wanted by the time they completed the third questionnaire (Table 5). More than half the patients (57.7%) indicated that the treatment choice had been a joint decision by themselves and their doctors. No statistically significant differences were found between patients consulting men and

**Table 2.** Patients' symptoms and past medical history, by sex of general practitioner consulted.

Reported symptom/ past medical history	% of women consulting	
	Man GP (n = 177)	Woman GP (n = 171)
<i>No. of GP consultations in past year<sup>a</sup></i>		
≤2	35.2	37.4
3/4	30.1	35.1
5+	34.7	27.5
<i>No. of previous surgical operations (any)</i>		
0	10.7	15.8
1	33.9	31.6
2+	55.4	52.6
<i>No. of previous gynaecological operations</i>		
0	41.2	44.4
1	37.3	33.3
2+	21.5	22.2
<i>No. of previous consultations for this menorrhagia episode<sup>b</sup></i>		
0	42.9	49.4
1+	57.1	50.6
<i>Presence of related symptoms (GP assessment)</i>		
Other bleeding problems <sup>c</sup>	18.1	18.1
New associated dysmenorrhoea	19.2	25.1
Fibroids suspected or confirmed	18.1	23.4
Anaemia suspected or confirmed	14.7	22.2
Premenstrual tension	34.5	39.2
Depression, stress, tiredness	46.9	52.0
<i>Symptom severity (GP assessment)<sup>d</sup></i>		
Mild	11.9	11.8
Moderate	53.1	52.1
Severe	35.0	36.1
<i>Symptom severity (patient assessment)</i>		
Mild	1.7	1.8
Moderate	47.5	52.6
Severe	50.8	45.6
<i>Social impact of periods (patient assessment)</i>		
Mild	13.6	18.1
Moderate	58.8	58.5
Severe	27.7	23.4

*n* = number of women patients in group. <sup>a</sup>Data missing for one woman consulting man GP so *n* = 176. <sup>b</sup>Data missing for two women consulting men GPs so *n* = 175 and for three women consulting women GPs so *n* = 168. <sup>c</sup>Includes intermenstrual or postcoital bleeding. <sup>d</sup>Data missing for two women consulting women GPs so *n* = 169.

women general practitioners according to preferred treatment received, treatment decision and patient satisfaction. Participation in the treatment decision was more common among patients consulting women general practitioners than among patients consulting men general practitioners. One third of the men general practitioners' patients (32.9%) indicated that they had not been involved in the decision about their treatment, whereas the proportion reporting no participation among the women general practitioners' patients was somewhat lower (26.3%). More patients consulting men general practitioners reported that they were very satisfied or satisfied with the care they had received (65.6%) than patients consulting women general practitioners (54.6%).

**Table 3.** General practitioners' predictions and patients' preferences for treatment, by sex of general practitioner consulted.

Treatment prediction/ patient preference	% of women consulting	
	Man GP (n = 177)	Woman GP (n = 171)
<b>GP prediction of likely treatment<sup>a</sup></b>		
Surgery	39.7	42.5
Drug therapy only	56.3	51.5
None necessary	4.0	6.0
<b>Patient initial treatment preference<sup>b,*</sup></b>		
Prefer surgery	18.1	10.5
Prefer drug therapy	15.8	19.9
Prefer minimal treatment	1.1	8.8
No preference	65.0	60.8
<b>GP assessment of patient treatment preference</b>		
Prefer surgery	15.3	11.1
Prefer drug therapy	18.6	22.8
Prefer minimal treatment	1.1	6.4
No preference	65.0	59.6
<b>GP-patient concordance in treatment preference<sup>c</sup></b>		
Prefer surgery	40.6 [32]	38.9 [18]
Prefer drug therapy	42.9 [28]	41.2 [34]
Prefer minimal treatment	0 [2]	13.3 [15]
No preference	73.0 [115]	67.3 [104]
Overall agreement	61.6	54.4
<b>Patient final treatment preference<sup>d</sup></b>		
Prefer surgery	35.6	29.2
Prefer drug therapy	14.7	21.6
Prefer minimal treatment	2.8	3.5
No preference	46.9	45.6

n = number of women patients in group. <sup>a</sup>Data missing for three women consulting men GPs so n = 174 and for four women consulting women GPs so n = 167. <sup>b</sup>According to first questionnaire. <sup>c</sup>[Baseline data]. <sup>d</sup>According to third questionnaire.  $\chi^2$  test for trend: \*P<0.05.

## Discussion

Although some indications of sex-associated differences in practice style were found in this study, the similarities between the treatment patterns of the men and women general practitioners were more striking than the differences. There was no evidence that men general practitioners were less aware than women general practitioners of their patients' treatment preferences or were less likely to prescribe a course of drug therapy as a potential alternative to surgical intervention.

There was a suggestion that patients consulting women general practitioners were less likely to be referred to a gynaecologist and were therefore less likely to be candidates for surgery compared with patients consulting men general practitioners. This difference was more marked in an earlier analysis of the data from the 425 patients who were entered into the initial phase of the study.<sup>24</sup> By the end of the present prospective study the differences had narrowed and were no longer statistically significant. It seems likely that women general practitioners are more reluctant to refer and spend more time trying various alternatives to surgery, thus delaying referral. It could also be indicative of women general practitioners' greater confidence in managing the condition in general practice without resort to specialist advice, perhaps as a result of their greater experience of treating gynaecological conditions owing to the fact that they see a higher proportion of patients with these problems.<sup>5,8,12</sup>

**Table 4.** Treatment received, by sex of general practitioner consulted.

Treatment/action	% of women consulting	
	Man GP (n = 177)	Woman GP (n = 171)
Drug therapy with or without other treatment	91.5	86.5
Referral to gynaecologist	63.8	56.1
Dilatation and curettage	20.9	18.7
Other diagnostic investigation <sup>a</sup>	63.3	68.4
Hysterectomy	22.6	21.1
Endometrial resection	20.3	14.0
Awaiting surgery	5.6	5.3
Total undergoing or awaiting surgery	47.5	39.2
No active treatment	4.0	4.1

n = number of women patients in group. <sup>a</sup>Endometrial biopsy, ultrasound scan, blood test.

**Table 5.** Patient satisfaction, by sex of general practitioner consulted.

	% of women consulting	
	Man GP	Woman GP
<b>Did patient receive preferred treatment? (n = 94/92)<sup>a</sup></b>		
Yes	80.9	81.5
No	19.1	18.5
<b>Who made treatment decision? (n = 158/152)<sup>b</sup></b>		
Patient	14.6	10.5
Doctor	32.9	26.3
Patient and doctor	52.5	63.2
<b>Patient satisfaction (n = 154/152)<sup>c</sup></b>		
Very satisfied	34.4	30.3
Satisfied	31.2	24.3
Neither satisfied nor dissatisfied	22.1	28.9
Dissatisfied	8.4	9.2
Very dissatisfied	3.9	7.2

n = number of respondents attending men GPs/women GPs. <sup>a</sup>Excludes those who did not have a preference. <sup>b</sup>Excludes those who did not have treatment. <sup>c</sup>Data missing in some cases.

The women general practitioners were, if anything, less accurate than the men general practitioners in their assessment of patients' preferences following the index consultation. However, 18 months later more of their patients reported involvement in decisions about their care compared with patients consulting men general practitioners. Despite this, patients consulting men general practitioners were more likely to say that they were satisfied with the treatment they had received. The picture is thus quite confused, but little support was found for the popular stereotypes of men general practitioners lacking understanding of gynaecological problems or instantly resorting to surgical treatment, and women general practitioners being more closely in tune with their patients' wishes because of their greater empathy and personal experience.

It is important to remember that although a considerable number of general practitioners participated in the study, it was not a random sample. It is possible that the general practitioners who were prepared to recruit patients into a study of this type were atypical in the sense that they were more than usually inter-

ested in the treatment of menstrual problems. Given the slow pace of recruitment into the study<sup>23</sup> this does not seem likely, but it is an important limitation of the study design. Nevertheless, the results of the present study are broadly in line with those of the studies cited earlier.<sup>13,14</sup> If there are differences between the sexes in practice styles, they are not nearly as dramatic as is popularly assumed. It seems more likely that the differences within the sexes are much greater than the differences between them.

## References

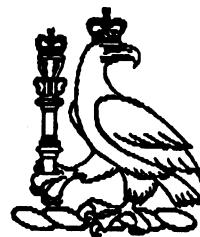
1. Department of Health. *Health and personal social services statistics for England*. London: HMSO, 1993.
2. Haar E, Halitsky V, Sticher G. Factors related to the preference for a female gynaecologist. *Med Care* 1975; **12**: 782-790.
3. Ackerman-Ross FS, Sochat N. Close encounters of the medical kind: attitudes toward male and female physicians. *Soc Sci Med* 1980; **14a**: 61-64.
4. Alexander K, McCullough J. Women's preferences for gynaecological examiners: sex versus role. *Women and Health* 1981; **6**: 123-134.
5. Gray J. The effect of the doctor's sex on the doctor-patient relationship. *J R Coll Gen Pract* 1982; **32**: 167-169.
6. Challacombe CB. Do women patients need women doctors? *Practitioner* 1983; **227**: 848-850.
7. Cooke M, Ronalds C. Women doctors in urban general practice: the patients. *BMJ* 1985; **290**: 753-755.
8. Nichols S. Women's preferences for sex of doctor: a postal survey. *J R Coll Gen Pract* 1987; **37**: 540-543.
9. Waller K. Women doctors for women patients. *Br J Med Psychol* 1988; **61**: 125-135.
10. Fennema K, Meyer DL, Owen N. Sex of physician: patients' preferences and stereotypes. *J Fam Pract* 1990; **30**: 441-446.
11. Graffy J. Patient choice in a practice with men and women general practitioners. *Br J Gen Pract* 1990; **40**: 13-15.
12. Bensing JM, Brink-Muinjen A, Bakker D. Gender differences in practice style: a Dutch study of general practitioners. *Med Care* 1993; **31**: 219-229.
13. van den Brink-Muinjen A, de Bakker DH, Bensing JM. Consultations for women's health problems: factors influencing women's choice of sex of general practitioner. *Br J Gen Pract* 1994; **44**: 205-210.
14. Sandvik H, Hunskaar S. Doctors' characteristics and practice patterns in general practice: an analysis based on management of urinary incontinence. *Scand J Prim Health Care* 1990; **8**: 179-182.
15. Coulter A, Klassen A, McPherson K. How many hysterectomies should purchasers buy? *Eur J Public Health* 1995; in press.
16. McMaster H, Arroll B. Screening for cervical cancer: attitudes and policies among Auckland general practitioners. *N Z Med J* 1992; **105**: 125-127.
17. Franks P, Clancy C. Physician gender bias in clinical decision-making: screening for cancer in primary care. *Med Care* 1993; **31**: 213-218.
18. Majeed FA, Cook D, Anderson HR, et al. Using patient and general practice characteristics to explain variations in cervical smear uptake rates. *BMJ* 1994; **308**: 1272-1276.
19. Duran R, Seymore C, Jay S, et al. Pediatric residents' assessment of adolescents' experiences during pelvic examination. *J Adolesc Health Care* 1987; **8**: 407-412.
20. Bradlow J, Coulter A, Brooks P. *Patterns of referral*. Oxford: Health Services Research Unit, 1992.
21. Vessey M, Villard-Mackintosh L, McPherson K, et al. The epidemiology of hysterectomy: findings in a large cohort study. *Br J Obstet Gynaecol* 1992; **99**: 402-407.
22. Coulter A, McPherson K, Vessey M. Do British women undergo too many or too few hysterectomies? *Soc Sci Med* 1988; **27**: 987-994.
23. Peto V, Coulter A, Bond A. Factors affecting general practitioners' recruitment of patients into a prospective study. *Fam Pract* 1993; **10**: 207-211.
24. Coulter A, Peto V, Doll H. Patients' preferences and general practitioners' decisions in the treatment of menstrual disorders. *Fam Pract* 1994; **11**: 67-74.
25. Coulter A, Peto V, Jenkinson C. Quality-of-life and patient satisfaction following treatment for menorragia. *Fam Pract* 1994; **11**: 394-401.
26. Office of Population Censuses and Surveys. *Standard occupational classification*. London: HMSO, 1991.

## Acknowledgements

We are grateful to all the general practitioners and practice staff who helped us with this study, which was funded by the Department of Health.

## Address for correspondence

Ms A Coulter, King's Fund Development Centre, 11-13 Cavendish Square, London W1M 0AN.



## FACULTY OF DENTAL SURGERY THE ROYAL COLLEGE OF SURGEONS OF ENGLAND Clinical Study Day on ORAL CANCER

### An Educational Programme for Prevention, Early Detection and Audit Friday, 13 October 1995

at THE ROYAL COLLEGE OF SURGEONS OF ENGLAND, LONDON

This study day will be of interest to general medical and general dental practitioners, public health and community practitioners, hospital specialists and epidemiologists.

This meeting has been approved for payment of the Postgraduate Education Allowances for general medical practitioners and general dental practitioners.

The full programme and application form may be obtained from

**Anne O'Mara, Courses/Meetings Co-ordinator**  
**Faculty of Dental Surgery,**  
**The Royal College of Surgeons of England,**  
**35-43 Lincoln's Inn Fields, London WC2A 3PN.**

**Tel: 0171 405 3474 ext 4062**

**Fax: 0171 973 2183**