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Sir,

In the August *Journal,* GPs are once again talking about urgent and emergency appointments or attendance at the surgery. These are emotive and value-ridden words, and I found, when I was a GP, that if I changed the question that the receptionist asked the patient to 'will it wait until the next surgery?', this removed pressure from the patient, from the receptionist, and possibly from the GP.

From the patient's point of view I found there was always a valid reason for the individual deciding the consultation would not wait until the next surgery. Often, it was not a truly medical reason, but at least the doctor's value system was not being imposed on the patient.

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Computerized appointment system in general practice

Sir,

We share the enthusiasm of the Rusholme Health Centre (August *Journal,* p 477) for the Informatica Front Desk clinical appointment system. However, there are many other benefits of this computer program that are not covered in the article, particularly its value in audit. Auditing DNA appointments in total, and individually for a patient, allows us to develop a strategy for addressing this problem. Similarly, a list of the most frequent surgery attendees (yes, they are seared into our subconscious as well) is illuminating.

The audit of clinical user time is now 'classified information' in our practice — the doctor who never starts on time, and the doctor who never finishes on time (not the same one), and whose patients waited longest to be seen. Waiting time after arrival is optional on-screen in the consulting room, but we find that commiserating with and apologising to patients can generally defuse their complaints. A quick glance on a Monday morning at the number of 'free appointments' in the week may make the heart sink, but the computer program produces a control and flexibility to add extra appointments at the most useful times, which was not easy to achieve with the manual system.

There were teething problems, perhaps because our staff received less than a third of the training time allowed by the Rusholme Health Centre. Initially, we were not sure that we needed a computerized appointment system; a year on and we would not be without it.

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Investigation and treatment of *Chlamydia*

Sir,

Penny Owen discussed the dilemmas in managing gynaecological infections in her editorial in the July *Journal.*[1]

It is helpful to identify that a small number of women will present to their general practitioner every year with potentially serious infection such as *Chlamydia trachomatis.* This clearly requires investigation and treatment. Chlamydial infection also demands investigation and management of the sexual partner to ensure that reinfection is avoided and permanent tissue damage prevented. There is indeed a dilemma in categorization for the general practitioner, and the experience of this department is that the history of risk of exposure in young adults (via a recent change of sexual partner) is a more reliable clinical marker of chlamydial genital infection than symptoms, in both men and women.

The author correctly goes on to identify issues of communication between primary care and genitourinary medicine. Perhaps some thoughts of one of the small number of vocational trainees who work in genitourinary medicine full-time during their hospital training rotation may be of relevance. There are dilemmas here for both specialties. For example, should vaginal examination be an appropriate clinical standard? It is clearly an ideal.

In reality there are constraints of time, and the possibility exists that important infections may still be missed. In genitourinary medicine all new patients at risk of sexually transmitted disease, or with symptoms suggesting such conditions, will be examined and offered detailed microbiology screening. The six months training experience in a busy genitourinary medicine clinic identifies just how misleading asymptomatic or low-grade chlamydial infections may be in the primary care setting.

Gynaecological infections do indeed cause additional management difficulty when they are recurrent, and genitourinary medicine has established systems for dealing with recurrent symptom complexes. Many but not all of these are due to reinfection by an untreated male partner.

The attendance of male and female patients together in this clinic is designed to reinforce the acceptance and understanding that many of these symptoms presented by women are in fact problems of couples. This approach is thought helpful in terms of young people's understanding of sexually transmitted disease (STD), and is appreciated by the patients attending.

The issue of communication between primary care and genitourinary medicine is fundamental and is rightly raised by Dr Owen. The ability to monitor and control epidemics of sexually transmitted diseases is dependent on individual patients revealing the most intimate and detailed aspects of their sexual history. The privacy and confidentiality afforded by genitourinary medicine facilitates this, but it is a long-held belief of this teaching department that the transfer of effective, prompt, diagnostic information to the general practitioner not only helps in primary care management, but increases the awareness and understanding of local epidemiological concerns in STD.

If we are to ask for increased use of genitourinary medicine clinics by primary care, then we in return have to increase communications with general practitioners. This interplay between the two specialties appears to be greatly facilitated by this senior house officer (SHO) training oppor-