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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 sex-

ual 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-

tunity, in that many ex-trainees are now principals in local practices; clearly, their referral patterns have changed.

Frequently, busy general practitioners will spend two or three minutes phoning the department to refer patients or request an immediate appointment, and this is always 'rewarded' (subject to the patient's informed consent) with a detailed report of management, microbiological diagnosis, and (where appropriate) whether a partner has been treated simultaneously. This has been found to be a very effective means of communication, while protecting the patient's absolute rights of confidentiality, which are defined by parliamentary statutes.

The key issue in communication is understanding and a commitment to share. Perhaps if more vocational training schemes had the opportunity for SHO appointments in genitourinary medicine, a wider perception might be achieved. This would increase the understanding of the importance of preventing the re-infection of gynaecological infection, and of contact-tracing in disease control in populations. There could be a much greater awareness of the very large numbers of patients with dangerous genital tract infections who have no apparent symptoms.

Such communication and understanding may increase the benefit to both the individual patient and the young adult population. Should this be achieved, surely it would produce a significant contribution to the *Health of the Nation* targets.²

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The methodological quality of megatrials

Sir,
In his discussion of the methodological quality of megatrials, Bruce Charlton (*July Journal* p 429) should have taken more

time to study the content of our paper on the type and quality of randomized controlled trials (RCTs)¹ before dismissing it as an example of a 'generalized interpretative approach based on statistical criteria and checklists'.² It is a far more robust approach than he suggests.

Empirical studies have demonstrated that bias (systematic error) is greatest when inadequate randomization occurs, in the form of defective or unclear concealment of treatment allocation.³ The consequence is that poorly randomized trials yield exaggerated treatment effects of between 30% and 40% when compared with properly randomized trials. These less rigorous studies are more likely to result in 'false positive' or exaggerated claims of efficacy (concluding that there is an effect when in fact there is not).³

In contrast, Charlton cites his own, non-empirical work when suggesting a 'knowledge of the identity and importance of specific interfering causes' in the interpretation of an RCT. He presumes that it is always possible to identify such causes when in clinical settings this is frequently not possible.⁴ For this reason, criteria have been developed as a check against selection, performance, exclusion and detection biases in RCTs.⁵

While acknowledging that there is no perfect method in the assessment of RCT quality, it seems that the method adopted by the Cochrane Collaboration and used in our study has the benefit of being valid, clear and straightforward.⁵

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Is there evidence that megatrials are based on a methodological mistake?

Sir,

In his discussion paper (*July Journal*, p 249) Bruce Charlton advises us of the substantial problems with megatrials. There may well be such problems, but we are concerned about the lack of evidence he uses to support his argument. In particular, Charlton provides no evidence to support his notion that the conduct (and presumably reporting) of megatrials are somehow worse than for smaller trials. We are not aware of any evidence to support this viewpoint. Furthermore, the paper takes up almost three pages and nowhere is there a definition of a megatrial. Does Charlton define a megatrial as one involving 500, 1000 or 3000 patients?

Although it is important to air viewpoints, there is evidence to indicate that opinion can lag behind the evidence by up to 10 years.¹ We wonder whether this is another example.

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Summative assessment

Sir,

I read with interest Campbell's and Murray's article on summative assessment (*July Journal*),¹ yet I cannot see how they came to the conclusion that registrars who failed were not competent to enter general practice. If this assessment is to identify registrars who fall below the standard for minimal competence, then there needs to be a definition of what minimal competence is. The authors obviously failed to do this with the MCQ paper from the Royal Australian College of General Practitioners, despite the use of the Angof