

Development of a questionnaire to measure patients' satisfaction with general practitioners' services

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SUMMARY

Background. It is now a requirement that patients' satisfaction with the services obtained from their general practitioner should be surveyed.

Aim. The aim of the study was to produce a reliable and valid multidimensional patient satisfaction questionnaire that could be used in general practice.

Method. Items were originally derived from patients' responses to open-ended questions. The resulting 148-item Likert-scale questionnaire was completed by 1193 patients. General satisfaction items were removed from the set, and responses to remaining items underwent factor analysis. Subscales were produced from items representing each factor. Reliability and validity of each subscale were examined.

Results. Five subscales with a total of 40 items resulted from the factor analysis: doctors, access, nurses, appointments and facilities. Each subscale was internally reliable (Cronbach's alpha coefficient between 0.73 and 0.95), and initial tests of validity suggested that all subscales were valid.

Conclusion. The study has resulted in a 40-item scale that has been found to be reliable and valid after initial tests. Further work to test the reliability and validity of the final version of the patient satisfaction questionnaire is described.

Keywords: questionnaire construction; research methodology; patient satisfaction; general practitioner services.

Introduction

THE 1990 contract for general practitioners instructs family health services authorities to carry out surveys of patients' satisfaction with general practitioners' services,¹ and medical audit advisory groups have a responsibility to ensure that patients' concerns are addressed in health service provision.² Information from patient satisfaction surveys can be used to assess the quality of the process and outcome of care, and may be used to choose between alternative methods of providing health care.³ Family health services authorities may choose to commission general practitioners to undertake surveys of patient satisfaction in their own practices. Some general practitioners may wish to undertake their own surveys in order to monitor per-

formance, determine patients' needs, plan the development of services, and provide evidence to support applications for financial support and expenditure.

At present there are few valid and reliable patient satisfaction questionnaires devised for use in general practices in the United Kingdom. Most studies use scales developed in the United States of America despite the lack of evidence that they are reliable and valid when used in the UK context.⁴ Other scales produce general measures of satisfaction which are not useful for assessing specific aspects of services,^{5,6} although Baker's work is a notable exception.^{7,8}

Previous USA^{9,10} and UK^{11,12} work on patients' satisfaction with health care has not been designed specifically to measure satisfaction with services provided by the general practitioner. Baker was the first UK researcher to produce reliable and valid scales designed to look specifically at satisfaction with general practitioners' services.^{7,8} He has produced two separate scales, one to measure patients' satisfaction with general practitioner consultations (the consultation satisfaction questionnaire)⁷ and the other to measure satisfaction with all other aspects of the service provided by the general practitioner (surgery satisfaction questionnaire).⁸ Both scales are carefully constructed and have the advantage of brevity. However, they have two disadvantages. First, they do not assess patients' satisfaction with practice nurses, which may be an important contributor to overall satisfaction with the practice.¹³ Secondly, the two questionnaires were developed separately and are designed to cover specific aspects of the service. It is likely to be more useful for general practices to have a single questionnaire that assesses all relevant aspects of care.^{3,5,6}

A study was undertaken to produce a valid and reliable patients' satisfaction questionnaire which could be used by general practitioners and family health services authorities in the UK. The study develops Baker's work to produce a multidimensional scale designed to ascertain patients' satisfaction with all aspects of general practitioners' services.

Method

Generation of patient satisfaction dimensions

The aim of the first stage of the study was the generation of a limited number of dimensions of patient satisfaction. These dimensions were designed to cover the range of views held by patients using the services, as well as aspects considered important by researchers and practitioners working in the area of patient satisfaction.

A literature review was carried out to produce a preliminary list of ideas about aspects of general practitioners' services that were likely to predict satisfaction. These were general satisfaction, doctor communication skills, doctor social skills, doctor competence, access to general practice services by telephone, access via transport, appointments, facilities, emergency care, treatment outcome, nurses and receptionists.

These aspects were incorporated into a 44-item open-ended questionnaire that could also be used as an interview schedule designed to assess patients' views of their last visit to the general practitioner and more general views of general practice. For

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example, questions included 'In what ways do you think your doctor is a good doctor?' and 'What do you like or dislike about the facilities?' The questionnaires were distributed to a convenience sample of 30 psychology students at Manchester Metropolitan University and 20 at Leeds University. Thirteen questionnaires were returned from Manchester and five from Leeds. Thirty one patients in a Norfolk practice were also interviewed by other patients who volunteered to act as interviewers, using the questionnaire as an interview schedule.

All 49 completed questionnaires were analysed thematically, following the guidelines laid down by Glaser and Strauss.¹⁴ Analysis revealed 10 themes (dimensions) that arose from the interviews and questionnaires and that characterized patients' responses. For example, respondents cited the following as examples of factors affecting satisfaction with practice nurses: 'The practice nurse gives good advice' and 'All the practice nurses have a warm and friendly manner'. These statements were incorporated into the 'nurses' theme. Themes were labelled as follows: doctor information getting, doctor information giving, doctor social skills, doctor competence, doctor time pressure, access, facilities, nurses, receptionists and general satisfaction. These dimensions formed the basis for the development of the patient satisfaction questionnaire.

Item generation for the selected patient satisfaction dimensions

The aim of the second stage was to produce statements to represent each of the 10 dimensions. The questionnaire and interview responses were used to produce a list of all statements that could be included in the final questionnaire, grouped under dimension headings. Redundant and overlapping items were then excluded from the list, leaving 148 items. Some items were reworded at this stage to make them suitable for a Likert scale format, and a five-point Likert agree-disagree response scale was added. Dimension headings were removed and item order was randomized to produce a 148-item questionnaire.

Distribution of questionnaires to patient sample

During January 1993, the 148-item questionnaires, comprising satisfaction items, questions on demographics and service use and a section that invited patients to list features of the practice that they particularly liked or which they thought could be improved, were sent out to a sample of patients in the same Norfolk practice. The list size was 6903 patients on 1 January 1993. There were 5576 patients aged 16 years and over, and the questionnaire was sent to 2788 of these after selection of alternate patients from an alphabetical list.

With each questionnaire was a covering letter from the practice partners. Patients were asked to complete the questionnaire anonymously and to return it to the practice in an enclosed stamped addressed envelope. Reminders could not be sent because of anonymity of responses.

Results

Patient sample

A total of 1193 completed questionnaires were returned (42.8%). Of 1177 patients who recorded their sex, 719 were women (61.1%) and 458 were men (38.9%). Of 1158 who recorded their age, the mean age was 52.1 years (standard deviation (SD) 18.7 years). Details of the age distribution of the sample are shown in Table 1. Respondents had made a mean of four visits to the practice over the preceding year (SD 4.3 visits). There were 409 responses to the section asking patients to list features that they particularly liked about the practice, and 360 responses identifying features patients thought could be improved.

Table 1. Age distribution of 710 women respondents and 448 men respondents in the sample drawn from the practice list.

Age (years)	% of respondents in practice age group	
	Women	Men
16-19 (<i>n</i> = 140/147)	15.7	9.5
20-29 (<i>n</i> = 428/388)	21.3	9.3
30-39 (<i>n</i> = 487/432)	23.6	14.4
40-49 (<i>n</i> = 475/497)	25.1	13.5
50-59 (<i>n</i> = 397/401)	27.2	15.2
60-69 (<i>n</i> = 392/398)	28.3	22.1
70-79 (<i>n</i> = 343/303)	32.4	29.0
80+ (<i>n</i> = 204/144)	16.2	22.2

n = number of women/men in age group in practice.

Patient satisfaction

Scores were reversed for all negatively worded questions so that in all cases a low score indicated satisfaction. Mean scores and standard deviations for each item were calculated and 55 skewed items (where most respondents indicated extreme satisfaction or extreme dissatisfaction) were discarded. Six questions designed to measure general satisfaction were then removed from the data set, to be used later to assess the construct validity of the main scale. The six items, and their mean scores (SD), were:

- There are one or two things about this surgery I am not happy about, 2.16 (1.29)
- I have absolute faith and confidence in doctors, 2.11 (1.17)
- I am not satisfied with my doctor, 1.68 (1.17)
- I feel perfectly satisfied with the way I am treated at the surgery, 1.68 (0.98)
- Patients receive the best care from the staff working at this practice, 1.60 (0.76)
- I have thought of changing to another practice, 1.45 (0.99)

The scores of the first, third and sixth items were reversed. Cronbach's alpha coefficient revealed that this subscale was internally reliable ($\alpha = 0.83$), that is, the items were highly inter-related.

Factor analysis

Principal components analysis¹⁵ of the remaining items revealed five factors which were labelled 'doctors', 'access', 'nurses', 'appointments' and 'facilities', based on the nature of items relating to (loading highly on) each factor. Items with a loading value of 0.5 or greater were retained for the final subscales. Table 2 shows the 20 items chosen for the 'doctors' subscale, together with the mean score (SD) and factor loading value for each item. The 'doctors' subscale explained 39.4% of variability in satisfaction scores, which means that patients' satisfaction with the practice was significantly affected by their satisfaction with their doctor. Other subscales were less important in determining satisfaction scores (access 6.0%, nurses 4.7%, appointments 3.9% and facilities 3.6%). The 20 items in the 'doctors' subscale were reanalysed using principal components analysis to examine whether this subscale would divide into the components identified by Baker.⁷ This analysis revealed high loading values (greater than 0.6) for all 20 'doctors' items and no statistically significant loadings on other factors, suggesting that this subscale was homogeneous, and so all 20 items were retained for the questionnaire.

Table 3 shows the eight items in the 'access' subscale and each of the four items in the 'nurses', 'appointments' and 'facilities' subscales, together with their mean scores (SD) and factor loading values.

Table 2. The 20 'doctors' items on the patient satisfaction questionnaire, showing mean scores, standard deviations (SD) and factor loading values.

Item	Mean score (SD)	Factor loading value
1. The doctor always puts me at ease	1.86 (1.08)	0.74
2. The doctor always gives me every chance to talk about all my problems	1.99 (1.11)	0.72
3. Even when the doctor is busy I am examined properly	1.80 (1.01)	0.72
4. The doctor is very careful to check everything when examining me	1.94 (1.08)	0.71
5. The doctor is very understanding	1.80 (1.00)	0.71
6. The doctor is always interested	2.02 (1.15)	0.71
7. The doctor shows a genuine interest in my problems	1.84 (1.04)	0.71
8. The doctor does enough tests to find out what is wrong	1.97 (1.09)	0.69
9. The doctor does everything needed to arrive at a diagnosis	1.98 (1.08)	0.68
10. The doctor clearly explains what is wrong before giving any treatment	2.01 (1.11)	0.68
11. The doctor fully explains how the illness will affect my future health	2.30 (1.18)	0.64
12. I do not feel rushed when I am with a doctor	1.95 (1.21)	0.64
13. The doctor always asks about how my illness affects everyday life	2.39 (1.22)	0.64
14. I sometimes feel I have not been given enough information by the doctor ^a	2.42 (1.31)	0.63
15. I do not feel confident discussing my problems with the doctor ^a	1.95 (1.23)	0.60
16. Sometimes the doctor makes me feel I am wasting his/her time ^a	2.26 (1.41)	0.59
17. The doctor seems to want to get rid of me as soon as possible ^a	1.88 (1.15)	0.59
18. The doctor does not tell me enough about the treatment ^a	2.39 (1.30)	0.57
19. The doctor knows when tests are necessary	1.80 (0.98)	0.56
20. The doctor sometimes fails to appreciate how ill I am ^a	2.23 (1.27)	0.51

^aScore reversed.

Internal reliability and validity

Cronbach's alpha coefficient for the complete 40-item questionnaire was 0.96, demonstrating high internal reliability. Each subscale was also internally consistent. The alpha coefficients were: 'doctors' 0.95, 'access' 0.85, 'nurses' 0.81, 'appointments' 0.83 and 'facilities' 0.73.

Face validity was checked by ensuring that the items which made up each subscale appeared to be reasonable measures of patient satisfaction. Content validity was investigated by checking that the patient satisfaction questionnaire covered the full range of patient satisfaction and that it did so in a balanced way.¹⁶ To test the construct validity of the subscales as measures of patients' satisfaction, Pearson correlation coefficients were calculated between total scores on each subscale and general satisfaction scores. All correlation coefficients were statistically significant ($r > 0.45$; $P < 0.001$; Table 4). Multiple regression analysis revealed that 71% of variance in general satisfaction scores could be explained by scores on the subscales. Beta weights revealed that all subscales contributed significantly to explaining variance in general satisfaction scores, with the 'doctors' scores showing the strongest predictive power (Table 4).

Table 3. The items on the 'access', 'nurses', 'appointments' and 'facilities' subscales of the patient satisfaction questionnaire, showing mean scores, standard deviations (SD) and factor loading values.

Item	Mean score (SD)	Factor loading value
<i>Access</i>		
21. The doctor is always available to give advice over the telephone	2.75 (1.15)	0.66
22. It is easy to get advice over the telephone	2.37 (1.06)	0.66
23. I feel it is easy to speak to my doctor by telephone	2.68 (1.23)	0.63
24. I can speak to a receptionist privately if I wish	2.70 (1.13)	0.61
25. The receptionists ask patients the right questions	2.03 (0.97)	0.57
26. The practice has good facilities for dealing with emergencies which occur when the surgery is closed	2.23 (1.00)	0.55
27. The receptionists explain things clearly to me	1.98 (0.97)	0.54
28. I am satisfied with the out-of-hours service	2.14 (1.15)	0.50
<i>Nurses</i>		
29. The practice nurses do not take care to explain things carefully ^a	2.00 (1.09)	0.75
30. The practice nurse does not always listen carefully when I talk about my problems ^a	2.06 (1.09)	0.74
31. The practice nurse makes me feel that I am wasting his/her time ^a	1.81 (1.05)	0.70
32. The practice nurse is always very reassuring	1.81 (1.81)	0.57
<i>Appointments</i>		
33. Getting an appointment at a convenient time is easy	1.96 (1.54)	0.69
34. Appointments are easy to make whenever I need them	1.94 (1.09)	0.67
35. It is often difficult to get an appointment with a doctor ^a	2.07 (1.27)	0.64
36. It is easy to see a doctor of my choice	2.11 (1.20)	0.60
<i>Facilities</i>		
37. The waiting room is uncomfortable ^a	2.00 (1.33)	0.77
38. The surgery building could do with some improvements ^a	2.00 (1.25)	0.72
39. The waiting room seats are uncomfortable ^a	2.30 (1.41)	0.70
40. There are not enough seats in the waiting room ^a	2.69 (1.52)	0.68

^aScore reversed.

In order to determine whether the patient satisfaction questionnaire differentiated between different user groups, comparisons were made between mean scores on the questionnaire. Women (mean score 2.10, SD 0.69) were significantly more satisfied than men (mean score 2.20, SD 0.70; $F(1,892) = 4.32$; $P < 0.05$). When patients were divided into five age groups (aged less than 30 years, 30–39 years, 40–49 years, 50–59 years, and aged 60 years and over), older patients were significantly more satisfied than younger patients ($F(4,881) = 53.59$; $P < 0.001$). For example, patients aged 60 years or more had a mean score of 1.76 (SD 0.60) and those aged less than 30 years had a mean score of 2.54 (SD 0.64).

Table 4. Mean scores, standard deviations (SD) and correlation coefficients between each subscale and general satisfaction scores, and β weights from multiple regression analysis.

Subscale	Mean score (SD)	Correlation r	β
Doctors	2.05 (0.83)	0.82***	0.63***
Access	2.40 (0.75)	0.64***	0.06**
Nurses	1.92 (0.82)	0.53***	0.04*
Appointments	2.03 (0.93)	0.61***	0.12***
Facilities	2.25 (1.02)	0.46***	0.13***

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$.

Discussion

The outcome of this research was a patient satisfaction questionnaire which, after initial tests, was seen to have adequate reliability and validity. The next stage in the research was to administer the questionnaire to other groups of patients to test the reliability and validity of the final version of the scale. Work is currently in progress involving distribution of the final version of the scale to patients in Norfolk, south Wales, and the north of England.

The response rate of 43% in this study was higher than is usual with postal questionnaires¹⁶ and was adequate for the purposes of this study. The proportions of men and women respondents in each age group were representative of National Health Service consultation rates,¹⁷ with higher response rates among women than men (particularly in the 16–49 years age group).

The high alpha coefficients of each subscale show that items in each subscale asked related questions. The internal reliability of the final version of the scale is currently being assessed with different patient groups and with a different mode of administration (as a self-completion questionnaire administered at the surgery instead of a postal questionnaire).

In order to assess the validity of the scale a number of procedures were followed. The final 40-item scale covered all topics mentioned by respondents in the interviews and questionnaires at the start of the study, and individual items covered areas identified in work on patients' satisfaction in the USA^{10,13,18} and UK.^{7,8,19} They also covered all comments made by patients when they were asked to list features of the practice that they particularly liked and aspects that they thought could be improved. This suggests that the measures had adequate content validity.

There was a statistically significant relationship between scores on each of the subscales and the general satisfaction scores, suggesting that all the subscales were valid measures of satisfaction with general practitioners' services. Construct validity was also tested by investigating whether sex and age differences in satisfaction, which are frequently reported in other studies,²⁰ would also be found using the patient satisfaction questionnaire. As expected, women were found to be more satisfied than men, and older patients were more satisfied than younger patients.

It was predicted, based on Baker's work,⁷ that a number of different 'doctors' factors might emerge from the data. Only one 'doctors' factor emerged, with 20 highly inter-related items covering information giving and getting, social skills, time pressure and competence. This finding suggests that patients show little discrimination between different aspects of consultations in terms of satisfaction. Further research is currently in progress to determine the reliability of this finding.

Another unexpected result was that 'appointments' constituted a separate factor from related areas such as 'access'. This supports Allen and colleagues' contention that appointment systems can be a major source of patient dissatisfaction.²¹ The formation of a separate subscale has practical value: in practices with no appointment system these items can be removed from the 40-

item scale without affecting the assessment of other aspects of access.

The patient satisfaction questionnaire may be of use to determine which areas of general practice patients perceive to be satisfactory and which they do not. It may be used to look at the effects of any change made in a practice by comparing scores before and after the change. Subscale scores can be used independently to look at particular areas of service provision, or the whole questionnaire can be used to produce a global satisfaction score if that is what a practice requires. It is likely that the individual subscale scores will provide more useful information when trying to understand patients' perceptions and when directing resources to particular areas of general practice.

General practitioners and staff at the Norfolk practice who took part in the study found that the results were useful, and that there were some areas of satisfaction/dissatisfaction that surprised them. Results were fed back through verbal and written reports, and a transcript of the patients' free comments. The staff suggested that practices intending to participate in or undertake surveys of patients' satisfaction must develop strategies which allow doctors and other staff to cope with the results constructively. They felt that any organization or individual discovering strengths and weaknesses will not be diminished by the experience. They found the open response space on the questionnaire particularly informative in adding depth of information to the numerical responses.

One of the major strengths of this questionnaire is that it enables patients to express satisfaction/dissatisfaction with different areas of general practice services, which many researchers have identified as a necessary feature of a useful satisfaction scale.^{3,5,6} Patients are considerably more likely to report dissatisfaction on scales that ask about specific areas of the service than those that ask more general questions.⁵ Patients' views on specific areas enable service providers to distinguish between genuine satisfaction/dissatisfaction and the general tendency of patients to report that they are satisfied.^{22–24} The questions chosen for the questionnaire were carefully selected in order that they did not produce positively skewed (that is, satisfied) responses, so it is hoped that this (and the specific nature of the questions) will minimize any tendency to positive bias. The patient satisfaction questionnaire uses the wording of the service users themselves, to make the questionnaire user-friendly to patients and to be as representative as possible of patients' views. It is hoped that this results in a questionnaire that asks about features of general practitioner services that are valued by patients, rather than those that managers or health professionals think are important to patients.

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