

LETTERS

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Laboratory request forms

Sir,
Laboratories are accustomed, although hardly reconciled, to receiving request forms with inadequate clinical information, which may adversely affect not only the diagnostic processing, but also infection control surveillance. While reviewing how surgical wound infections were investigated in the laboratory, with particular attention to the phage typing of *Staphylococcus aureus* from wounds associated with prosthetic implants, and cardiac, vascular and general surgery we suspected that many specimens, often from general practice, labelled simply as 'wound swab', should have been included in this group. The term 'wound swab', as employed by laboratory users, covers a wide variety of lesions, ranging from both surgical and traumatic wounds to pressure sores and ischaemic ulcers.

A survey was undertaken of the first 100 specimens submitted to the laboratory between 25 May and 25 June 1994 that were labelled 'wound swab' with inadequate clinical details. Doctors who had submitted poorly filled in request forms were telephoned in order to discover if the swab was from a surgical wound and, if so, the details of the operation and the name of the surgeon.

Of the 100 specimens 47 were from general practice, 40 were from two acute hospitals and the remaining 13 were from miscellaneous health care facilities. A total of 38 specimens (14 of which were from general practice) were from operation wounds, 14 of which were orthopaedic procedures and four were from cardiac operations.

In four of the 38 specimens, the telephone information radically affected the laboratory interest in the outcome. In two cases enterococci were isolated, and required sensitivities as they originated from wounds following orthopaedic implants. The other two specimens grew *Staphylococcus aureus*, which were phage typed, and were given a wider range of susceptibility tests since they originated from orthopaedic implants.

Thirty four of the 38 specimens would have required further testing had a significant pathogen been isolated. Of particular

interest were the four cardiac surgical cases. They were transferred from the regional centre outwith the area. It would have been useful to know this information from the outset, since major centres often have endemic organisms with wide ranging antibiotic resistance, for example, methicillin-resistant *Staphylococcus aureus* and high resistance enterococci, both of which are unusual in this area. Methicillin-resistant *Staphylococcus aureus* in particular may pose problems, as it may not perform well in routine screening for coagulase production by commercial kits and may be misidentified.

Surgical wound infection is likely to be used as a measure of quality of care and all doctors, whether from hospital or general practice, must have the patience to give adequate details on the request form if there is to be any prospect of collecting meaningful statistics and of improving treatment of patients.

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Chlamydia trachomatis

Sir,
We were interested to read the paper by Dryden and colleagues demonstrating a 5% prevalence of *Chlamydia trachomatis* infection in urine specimens from men and women aged 16-57 years, with a much higher rate in the 16-20 years age group.¹ We assume that this represents a symptomatic population, but as many infected individuals, particularly women, are asymptomatic, we would like to present the results of a small study (funded by a grant from the Scottish Home and Health Department) designed to estimate the prevalence in asymptomatic women.

Over a three month period in 1992, 10 general practices from a number of areas in Fife Health Board were asked to enter

patients into the study. All women aged between 15 and 40 years attending the practices for routine cervical cytology were asked to participate. Women complaining of a vaginal discharge were excluded. Following the taking of the cervical smear, an endocervical swab was taken using a plastic shafted cotton tipped swab (Medical Wire and Equipment company). This was placed in chlamydia transport medium (Northumbria Biologicals) for chlamydial testing at Fife area laboratory. The specimens were examined by a centrifuge-enhanced direct immunofluorescent monoclonal antibody (Microtrak®, Syva) for the presence of elementary bodies.²

Five specimens from 287 women (1.7%) were positive for *C trachomatis*. There were no infections in women between 30 and 40 years of age, making the prevalence of infection 3.5% (5/145) in women aged less than 30 years. In none of the chlamydia positive patients was the smear reported as inflammatory (four were negative and one was borderline). None of the five women with chlamydia infection was using a barrier method of contraception.

This study demonstrates an unexpectedly low prevalence of chlamydial infection among asymptomatic women attending for routine cervical cytology compared with 9% and 12% reported in other studies.^{3,4} However, in keeping with other studies those women with infection were in the younger age group and were not using barrier contraception.⁵ The presence of an inflammatory smear was not a useful criterion in 'targeting for testing' in this and other studies.^{3,4}

General practitioners are ideally placed for screening asymptomatic women, although it is possible that those at high risk of infection do not attend their general practitioner for cervical smears but have smears done elsewhere, for example, family planning clinics, or do not have smears done at all. We recommend that screening for chlamydial infection be considered in a selected population on the basis of age and contraceptive method, regardless of the presence or absence of symptoms. Close cooperation between general practitioners, practice nurses and genitourinary medicine services will allow

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 them-

selves '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