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On throwing out the baby and keeping the bathwater

Sir,
Grogan and colleagues (October *Journal*, p.525) reported the design and development of a 40-item questionnaire intended to measure patients' satisfaction with general practitioners' services. Such instruments can be valuable in identifying sources of dissatisfaction among patients, which is an essential first step towards resolving problems and improving services. However, the value of such questionnaires is heavily dependent on the generation and selection of items, and in this respect, the methods used by Grogan *et al* give cause for concern.

Items were generated from responses to open-ended questions about the respondents' last visit to their general practitioner and other less specific views of general practice. However, responses were restricted to 13 psychology students at Manchester Metropolitan University, five psychology students at Leeds University and 31 patients from a general practice in Norfolk. There was no information given about the general practice services used by the student groups though; if many were using their university general practice services, the views elicited will refer to a rather limited selection of general practices and their particular sources of dissatisfaction.

The responses of this particular sample were used in constructing an initial questionnaire which was sent to 2788 general practice patients from the same Norfolk practice used for item generation. This will tell us a great deal about sources of satisfaction and dissatisfaction with this particular Norfolk practice, but will do nothing to ensure that the questionnaire is relevant to other practices.

However, the most worrying aspect of the questionnaire development procedure reported came later when items were selected from among those used in the initial questionnaire for inclusion in the version to be recommended for future use in other practices. The authors told us that, '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.' While skew of responses might be an appropriate selection criterion in the development of psychological scales intended to detect differences between individual respondents, it is not appropriate in the development of a measure of patient satisfaction which is intended to inform us about the service and not about individual users of that service. If there are features of the service with which all or most patients are dissatisfied, then it is essential to include items concerning those features if the most urgently needed improvements are to be made. To exclude them is to ignore the very features of the service about which the majority of the patients have complaints and which are most in need of change. Excluding the items which elicited extreme scores indicating that patients are satisfied is more readily understandable though expressions of satisfaction in one practice are no guarantee that patients will report themselves to be equally satisfied in other practices.

Selecting items which give a normal spread of scores in one Norfolk general practice has resulted in a questionnaire which excludes those aspects of the service about which there is greatest consensus of patients views. The reader can only speculate about the nature of the items excluded because most patients found that aspect of the service unsatisfactory, but missing from the items retained are many common sources of dissatisfaction including waiting times, lack of privacy, not being treated as a person and lack of continuity of care. If Grogan *et al* could tell us more about their discarded items, it would provide a useful starting point for a patient satisfaction questionnaire which has a greater likelihood of stimulating improvements to general practice services than the questionnaire they recently recommended for future use.

CLARE BRADLEY

Reader in Health Psychology
Department of Psychology
Royal Holloway, University of London
Egham, Surrey TW20 0EX

Multimedia teaching and learning: transforming the culture of higher professional training?

Sir,
With the arrival of the medical world's first fully multimedia distance learning Masters Programme, we believe the time has come to step up the debate on the higher professional training needs of service general practitioners in this country.

The RCGP has called for an increased and innovative use of new technology to deliver home- and workplace-based learning,^{1,2} and has criticized the lack of learner input into the content and running of the courses currently available.³ Lindsey Smith pointed out that there are only 50 general practitioners in the UK currently undertaking an MSc course,⁴ and criticized the inflexibility and inappropriate content of those courses.

The MSc in General Practice Medicine from the University of Derby is the only programme in the UK fully designed and written by full-time general practitioners — in other words, by a peer group of the learners themselves.

Multimedia was chosen not as a compromise option but as a positive choice by professionals who posed the question: 'What would we need to go through to feel in masterly control over our working lives with the minimum sacrifice of time, money and autonomy?'

Multimedia teaching and learning (MTL) is the use of text, graphics, video and audio in computer applications. It is used to simulate the decision making environment of day-to-day life in general practice. The various theories and models which constitute our science of medicine can be applied and experimented within these simulated circumstances. The critical analysis and mastery of these models and theories represents the hallmark of Masters or level 4 postgraduate work. The opportunity to test drive these models in simulated situations represents the great strength of MTL.

The Internet is used in the delivery of some lessons which take the form of electronic discussion groups. There are also