provincial clinic seeing around 4500 new cases a year. In two weeks 116 calls were made for results and 65 for advice (roughly 9000 annually). Most of these calls were dealt with by clerical and nursing staff, but to do so adequately they require experience and training. If telephone calls are to be used more their use should be included in routine statistics and the demand they make planned for.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;**304**:1396. (30 May.)

EDITOR,—The subheading of Charles Collins's editoral on implementing the patient's charter in outpatient services seems naive.[1] Perhaps more resources are needed? Perhaps many of those who, like me, practise mainly in outpatient clinics may be permitted a hollow laugh. I have no doubt that Collins is right in everything he says, but being right is not always practical, nor is it necessarily fair.

My new patients are booked at 10 minute intervals. If I adhered to Collins's standard of 20 minutes for a new patient I would have to cut my clinics in half, even without allowing spaces for emergencies. As over the past six weeks I have received about 25 referral letters weekly for my 18 clinic appointments this might be expected to increase the waiting time for a routine appointment—presently five months. It would also increase the number of patients who forget their appointment, and I would then sit twiddling my thumbs.

We should heed the lesson of the "rubber windmill"; unless there is a massive increase in consultant manpower quality must be sacrificed. In our unit the need for two obstetricians, an orthopaedic surgeon, and an anaesthetist is paramount yet unaffordable, so what chance do I have?

Of course the advent of fundholding practices will enable me to make contracts appropriate in quantity to my quality standards. I estimate that this would enable me to exclude from my clinics the patients of one half to two thirds of local general practitioners. Somehow I don't think this would go down very well. Which is better: to provide a reasonable service to all or a perfect service to a few? I have suggested before that patients prefer to have a half hour wait to be seen in a clinic than to suffer an extra delay for an appointment in the first place.[2]

It is also worth noting that the charter does not actually require patients to be seen within 30 minutes of their appointment time, only that a reasonable explanation is offered if they are not so seen. So far that has not proved a problem.

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1 Collins C. Implementing the patient's charter in outpatient services. *BMJ* 1992;**304**:1396. (30 May.)
2 Bamji AN. "No show" fines [letter]. *Times* 1989 June 20.

Trusts need local negotiating committees

EDITOR,—Hart refers to the urgency with which all trust hospitals and potential trust hospitals should set up local negotiating committees and to these committees' need for help and guidance from the BMA's regional industrial relations offices.[1] Hart also reports that the most successful region in this respect is Mersey, where all the trusts have local negotiating committees. This is largely due to an active regional office and a conscientious industrial relations officer.

Hart states that provision has been made in the BMA's budget to expand the regional staff if required. Yet only this week I have learnt that the finance and general purposes committee is proposing that Mersey regional office should be closed. This does not seem to make any sense, and I urge a rapid rethink.

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1 Hart. Vigilance in the face of bullishness. *BMJ* 1992;**304**:1530. (13 June.)

BMA's view on generic substitution

EDITOR,—I must correct the information given by David Taylor in the first paragraph of his news item on generic substitution becoming law in the European Community.[1] He states that the BMA vigorously supported the Greenfield committee's recommendation that pharmacists could substitute a generic medicine for a branded one unless the doctor had specifically vetoed this. The truth is actually the opposite.

In its response to the Greenfield report the General Medical Services Committee proposed that the prescriber should have to make a positive indication on form FP 10 when generic substitution by a pharmacist was acceptable.[2] At all other times the medicine should be dispensed as written. The GMSC has not changed its policy and continues to believe that a positive opt in is safer and more appropriate than an option by default.

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1 Taylor D. Generic substitution may become EC law. *BMJ* 1992;**304**:1529. (13 June.)
2 General Medical Services Committee. *Annual report*. London: GMSC, 1983:appendix VI.

Consultants' communications with general practitioners

EDITOR,—Graham Read raises an important issue.[1] As a result of the new Access to Health Records Act can general practitioners and consultants still communicate honestly by letter? Patients may ask for access, see the information (including results), and become worried.

There is evidence accumulating from around the world that record access is safe. Denmark has allowed access since 1989 without problems[2] and, in both the United States[3] and Europe, with outpatients[4] and inpatients,[5] and in general practice,[6] record access does not lead to fear and trauma for patients. The reason is simple: those who request access want to know. They want to know the bad news as well as the good.

In our practice for the past six years we have allowed access in a more liberal fashion than the act currently allows: patients are handed their notes in the waiting room and have time to read them if they wish. We have found that patients welcome this move, find it reassuring, and think that it enhances the doctor-patient relationship. About 40% choose not to read their records but are satisfied with this arrangement.[6] Most people are well able to decide for themselves.

Read is reluctant to expose his patients to the truth because he is concerned that it may hurt them and, in the process, risks offering too little information to the general practitioner so that the care of the patient is jeopardised. This approach, although well meaning, is essentially patronising to the patient, apart from being risky. If patients choose to have information about themselves and to go through the barriers the act puts in their way, then they are entitled to that information. The doctor's job is to translate the technical information and put the results into perspective, as Read shows he could ably do.

The act gives us an opportunity to relate more honestly to patients and to demystify medicine to some extent. We should take that opportunity, not avoid it. The answer to Read's dilemma is to carry on writing the letters he always wrote. Both patients and the system will cope admirably.

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1 Read G. Consultants' communications with general practitioners. *BMJ* 1992;**304**:1248. (9 May.)
2 Andersen T. Danish experience of statutory right of patients to access hospital records. *Lancet* 1988;ii:1428.
3 Golodetz A. The right to know: giving the patient his medical record. *Arch Phys Med Rehab* 1976;57:78-88.
4 Hertz C. Patient participation in the problem-oriented system: a health care plan. *Med Care* 1976;xiv:77-9.
5 Steven D. What happens when hospitalised patients see their own records? *Ann Intern Med* 1977;**86**:474-7.
6 Baldry M, Cheal C, Fisher B, Gillet M, Huet V. Giving patients their own records in general practice: experience of patients and staff. *BMJ* 1986;**292**:596-8.

EDITOR,—I cannot agree with Graham Read's comments regarding passing information concerning the extent of severe illness and its prognosis to general practitioners.[1] General practitioners are often asked to explain what has occurred at hospital clinics, where anxiety and bewilderment are likely to interfere with full comprehension of what has been said. Often we are asked for advice about future management, and, though we are unlikely to be experts in oncology, we may have an overview and a better understanding of a patient's particular position. We need the information on what has been found and disclosed by the specialist team and may also need to prepare ourselves for future management.

Read expresses a concern that patients may wish to see the letter and be upset by what they read. If patients wish to see the letter this suggests that they want to discover the truth. Though they may be upset initially, patients are often better able to handle reality than the doctor may conceive. Ley quotes several studies which showed that over a third of patients considered that they had not been given enough information, though he comments that telling patients in itself is not enough.[2] They have to be told in ways they can understand and remember. As communicators, doctors need to learn how to explain "residual thickening" or "slight nodal enlargement" without causing unreasonable alarm. If a patient wishes to remain ignorant written evidence will not be requested. There may be exceptions, but that is for the general practitioner to decide at the time of the request.

If we expect patients to trust us we should not cheat, and we should trust patients to make their own judgments about how far they seek for the truth. There is no place for a letter that requires a doctor to read between the lines.

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1 Read G. Consultants' communications with general practitioners. *BMJ* 1992;**304**:1248. (9 May.)
2 Ley P. *Communicating with patients*. London: Croom Helm, 1988.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.