TABLE 11—Improvement in nocturia from day one to four and days eight to 11 in 28 women with the urethral syndrome

Groups	Days			Difference
	1-4	8-11		
"Got better" (n=18)	4.00 (1.18)	3.22 (1.35)	2.78 (2.83)	t=0.08; p=0.001
Mean (SD)				
Placebo (n=11)	0.64 (1.51)	3.28 (1.82)	3.36 (2.42)	t=1.61; p=0.001
Mean (SD)				
Dyspareunia (n=10)	8.20 (2.57)	4.60 (1.36)	3.60 (1.92)	t=2.96; p=0.02
Mean (SD)				

*Student's t test

TABLE 12—Improvement in dysuria from day one to four and days eight to 11 in 28 women with the urethral syndrome

Groups	Days			Difference
	1-4	8-11		
"Got better" (n=18)	1.11 (1.49)	0.33 (1.02)	0.78 (1.40)	t=2.30; p=0.05
Mean (SD)				
Placebo (n=11)	2.45 (1.57)	0.72 (1.62)	1.73 (1.62)	t=1.54; p=0.01
Mean (SD)				
Dyspareunia (n=10)	2.60 (1.65)	1.40 (1.65)	1.20 (1.15)	t=2.45; p=0.05
Mean (SD)				

*Student's t test

improved between days one to four and days eight to 11 and there were no significant differences between the groups.

Sixteen of the patients had pyuria, seven of them in the "got better" group and nine in the trial group. None of the urethral or cervical swabs yielded chlamydia nor was *N. gonorrhoeae* isolated from urethral or cervical swabs. Seven specimens yielded lactobacilli (10^6 ml) (one being *C. difficile*) and one lactobacilli (10^6 ml). Four of these specimens had pyuria and four had no pyuria. At review on day four, three of these patients were among the "got better" group, while five who were still symptomatic were entered into the trial and improved with time without specific antimicrobial treatment.

In the six months before a study quarter of the patients with the urethral syndrome had consulted their doctor with symptoms of frequency and dysuria. In a median observation time of 12 months after the study none of the patients had presented again with urinary symptoms.

Discussion

Intensive efforts have been made to find a microbiological cause for the urethral syndrome. Stamm *et al.* in a case control study using campus students, found an association between urinary symptoms with pyuria and chlamydia.¹¹ Bana, in a genitourinary clinic in Cardiff, recovered chlamydia from 13% of patients presenting with frequency and dysuria.¹² Like Burney *et al.* we were unable to isolate chlamydia from patients presenting to their general practitioners with frequency and dysuria.¹³ It is unlikely that delay in transport from practice to laboratory or errors in laboratory technique could account for this negative result because quality control specimens survived the system as did specimens taken by doctors for diagnosis in other clinical situations. Furthermore, the same laboratory has had long experience in dealing with the culture of chlamydia and recently reported an isolation rate of 13% from the local genitourinary clinic.¹⁴ It is more likely that the nature of the population studied is an important factor in determining the overall incidence of chlamydia. Chlamydiae have been isolated from 12 to 31% of women attending genitourinary clinics.¹⁵⁻¹⁷ There was a much higher isolation rate when the patients had gonorrhoea, *Trichomonas vaginalis* infection, or when the woman was in sexual contact with a man who had non-specific urethritis.¹⁸ When asymptomatic patients in a family planning clinic were investigated for urethral and cervical chlamydia infection, however, the incidence fell to 3%,¹⁹ and to 1%,²⁰ when specimens from hospital staff volunteers had been cul-

tured for genital chlamydia (table V). Schacter *et al.*²¹ reported an isolation rate of 3.5% from the urethra of asymptomatic women who attended screening and well woman clinics; but when the same authors investigated symptomatic women who attended acute walk-in clinics the incidence of chlamydial isolation rose to 15.6%.

There is a great risk in extrapolating findings from any selected population on to a more general population. The incidence of chlamydia in genitourinary clinics probably does not represent that in a general practice population. Patients who suspect a venereal cause for their symptoms may elect to attend the more anonymous genitourinary clinic, thus distilling themselves into a selected population. Chlamydiae as eye pathogens, however, occur sporadically and may also be sporadic genital pathogens. It would be interesting to determine if there is such a sporadic pattern in the general population; longitudinal studies with particular emphasis on the demographic features of such a population would have to be done.

In the study reported here lactobacilli were found in eight patients, all of whom improved symptomatically in a short time without specific treatment. Maskell *et al.*¹³ suggested slow growing and carbon dioxide dependent organisms as a cause of the urethral syndrome, based on specimens referred to a laboratory.²² Maskell's hypothesis has been controversial,^{23, 24} and Brumfit *et al.* in a case control study using volunteers, pregnant women, and symptomatic patients, found lactobacilli equally prevalent in all three groups.²⁵ As lactobacilli are commensals in the vaginal flora caution needs to be applied

TABLE 13—Isolation of chlamydia from different populations of women who were both asymptomatic and symptomatic

Author	Location	Percentage of chlamydia isolation	Population
Schacter <i>et al.</i> ²¹	San Francisco	15.6	Symptomatic acute "walk-in"
Schacter <i>et al.</i> ²¹	San Francisco	3.5	Asymptomatic screening
Hilton <i>et al.</i> ¹⁵	London	11.9	Genitourinary clinic
Hilton <i>et al.</i> ¹⁵	London	3.1	Family planning clinic
Burney <i>et al.</i> ¹³	Cardiff	26	Genitourinary clinic
Holliday and Watt ¹⁴	Manchester	26	Genitourinary clinic
Stamm <i>et al.</i> ¹¹	Washington DC	20	Asymptomatic hospital staff
Stamm <i>et al.</i> ¹¹	Washington DC	13	Genitourinary clinic
Brumfit <i>et al.</i> ²⁵	Cardiff	13	Genitourinary clinic
O'Dowd <i>et al.</i> ²⁰	Cardiff	0	General practice

*Symptomatic

before attributing a pathogenic role to these fastidious organisms. Furthermore, applying Kass's quantitative criterion of 10^6 organisms/ml of urine to the urethral syndrome, which is a criterion applies to microaerophilic and anaerobic organisms. Indeed, having such a quantitative cut off count may be unhelpful in such infections which may well need to be assessed on their individual clinical features with laboratory help. In this study the findings of lactobacilli were too few to provide a definitive answer but they seem to support Brumfit's contention that these organisms are not causally related to the urethral syndrome.

The findings of our study indicate that each monitored episode of the urethral syndrome was short and self limiting. The numbers of patients admitted to the therapeutic trial were small because nearly half the patients reported that they had "got better" in the four day interval while awaiting the result of the midstream urine specimen culture. Of the patients admitted to the trial, there was no difference between those on doxycycline and those on placebo. Though the premonitory duration of the "got better" group—that is, those who said that they were better at review on day four—was statistically significantly shorter than that of the trial group and though the "got better" group recovered more quickly, this might still be part of the same illness, of differing severity with some taking longer than others to improve.

rule. The National Health Service is content to leave the education of reception staff to their employers, and we are content to recruit unorganised labour with minimum preparation for the minimum services.

Endless paperwork loading the quantity, but never the quality, of our work is promoted by fees for items of service, and by capitation itself. Time and energy are diverted from clinical medicine, its management, accounting, and financial planning, disciplines for which we have no training and for which all but an entrepreneurial few have little inclination.

Worst of all, pessimism and resignation have become normal moods among other health workers, though the long observation of our independence. "Where do general practitioners go in the afternoon?" asked a consultant running a hypertension clinic in a health centre empty of doctors—save him. For him it was a mystery, like where flies go in winter, but we know it as a privilege of our special status. Consultants thank us for "helpful" letters and the enthusiastic specialist cautiously—so cautiously—promotes the shared care programmes necessary for the management of chronic disease. General practice is a weak base for clinical medicine, in the cities not in the shires, because our independence makes us unavailable and unreliable. Yet we are not really independent. Public money subsidises such premises as we find and redevelop, the staff we recruit, and our growing expectations of larger incomes, reduced working hours, and more leisure time. Unlike hospital

consultants we do not have to bargain and compete for resources, nor do we have to provide specific services for a defined community. Unlike consultants we cannot marshal even the minimum reserves for emergency primary care outside the limited network of "centres of excellence"—the health centres. Only partly subsidised, we are closer to the state subsidised peasant farmers of the European Economic Community, kept on little plots of land by taxpayers' money, than to our salaried colleagues in the industry of hospital medicine.

Soothing away the irritation may mean becoming dependent. Even though our independence is not real, allowing plenty of time for hobbies to blossom and empires to grow, dependence might still be worth while. Urban general practitioners need better premises and adequate records. We need training for existing staff and new sources of skills in epidemiology and medicine. Closer support, guidance, and even direction from hospital specialists may be required if general practice is to develop a major role in clinical medicine, taking over the role of routine management of chronic disease, "walk-in" clinics, and "outreach" programmes. Resources, human and material, can cure this ache if carefully and thoughtfully applied. If the price of medical care truly based on the general physician is the loss of schedule D status and of the petty liberties of the small shopkeeper, so be it. Rub on the resources! Then I will concentrate on homicidal dogs, relentless telephones, nagging psychopaths, and all the other pleasures of everyday life.

Minimum Standards for Training

Minimum standards for training practices

MIKE PRINGLE

In attempting to define minimum standards it is presumed that there are agreed criteria for quality in general practice. Though a few practices may be universally regarded as lamentable, others are thought of as excellent by independent doctors. These "excellent" practices may have exemplary practice organisations but be regarded by some of their patients as impersonal. And what of all the practices in between? If we analyse our own practices it is often those aspects that are unusual or unique that we are most proud of. Any standards of quality must infer conformity, and this is something that doctors resist. Defining quality, and thus minimum standards, is therefore both impractical and unhelpful.

Discussing reasonable expectations rather than minimum standards may be more worth while, but only with certain provisos. A trainee is likely to spend his subsequent career in no more than two practices, and his training should prepare him specifically for the first of these. Because the average trainee joins the average practice, should we set our sights at preparation for the average real world with the average patient presenting average medical, psychological, and social conditions? Obviously this is fallacious. Only when we have a

clear objective in training can any assessment be applied to a training practice. I believe that trainees should be shown the levels of care to aspire to and emulate because on this depends the future of general practice.

It also helps that the physical trappings of a practice are much less important than the attitudes of the staff. It is not essential for a practice to have good premises but it is for a trainee to become aware of the shortcomings in premises and the methods of correcting them. Much more may be learnt from observing a practice planning a health centre than from working in one without discussing its design.

In discussing reasonable expectations of a training practice I am talking more about attitude than reality: more about the process of change than the state so far achieved. If practices fail to compare favourably with others a trainee has the right to expect the partners to acknowledge this and discuss solutions. This does not mean reflex conformity. If a practice can justify in detail the absence of an appointments system a trainee will at least be exposed to one side of a vibrant argument. Working in a practice with an appointments system that is never questioned or altered is likely to be less educational.

The attitudes and working methods of partners and particularly of trainers are also important. It is assumed, perhaps unwisely, that all trainers are clinically competent and capable of passing clinical knowledge on to trainees, but the "atmosphere" of a practice can affect the trainees just as much as it affects patients. On visiting practices during surgery hours,

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Brooks cited an annual incidence of 48/1000 women over the age of 15 years with the urethral syndrome;¹ the results of our study show an incidence of 15/1000 women per year. Our results, however, showed that for a median observation period of 12 months after the study there were no recurrences of frequency or dysuria, or both, reported to the doctor from among those patients with the urethral syndrome. Extrapolating from the figures from before the study there should have been 16 recurrences in six months in addition to new cases. The discrepancy between observed cases of the urethral syndrome and the expected numbers may be an example of the Hawthorne effect—that is, a study population being affected and altered by the process of being studied.² The investigations may have deprived these women of their focus of complaint and caused them to focus on another area of their bodies or, alternatively, the investigations either frightened them away or reassured them sufficiently to allow them to tolerate any new symptoms. There is thus a need to clarify any effect that the investigations may have had on these patients and how they perceived them.

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What Annoys Me Most

Independence

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What irritates me most about general practice? My independence, of course! All other irritations are minor, by comparison.

Our independence shapes each day's work. The converted, make shift premises that are the norm of urban medicine are evidence of chronic underfunding, legitimised by our independent status. We are free practitioners and make our own world and work. We do it so well that inner city family practitioner committees seek out those who do not ask for help with refurbishment of premises, and tempt them with double size grants. Renovation, conversion, and improvement are events worth recording in free papers, as news, to show that

it is possible to haul oneself up by the bootstraps. In the urban landscape the ideal of the liberal professional integrates alongside other comforting myths about stable marriages and happy families: providence and thrift; "a fair day's pay for a fair day's work"; and equality before the law.

We have a waiting list for A&R records, and guesstimated Lloyd George envelopes are on ration, it seems. "How to use records" is still taught on half day courses in vocational training schemes, and the idea of writing for communication rather than as an aide memoir dawns only slowly on group practices, where free flow of patients demands clarity, accuracy, and legibility, for continuity's sake. The imposition of minimal standards of record keeping in training practices—the elite cadre of general practice—provokes anxious debate and querulous complaint. Summaries, chronologically ordered continuity sheets, and well weeded letters are a threat to our independence, and therefore to our art and craft.

Reception staff may be the all important public face of the health care, but effective training that is the exception, not the

talking to reception staff over coffee, and listening to the rapport between partners it is possible to detect at a highly unscientific level an atmosphere that expresses the character of the practice. Some practices are dowdy, even uninteresting; others are vibrant, slightly mischievous. Some are earnest and academic; others exude a lighter, even humorous air. This atmosphere will be a seminal influence on a trainee and originates from the personalities within the practice and how they interrelate; it is, of course, impossible to measure.

Reasonable expectations

Given these obstacles to defining even reasonable expectations in a training practice, some broad areas do nevertheless seem to reward attention. These are just as applicable to non-training practices, in which self analysis is no less important and there is no rota of fresh trainee minds to stimulate critical thought. I think it reasonable to expect a practical commitment to preventive medicine; antenatal and developmental clinics should be held in practices, and apparently healthy patients should be screened either as a regular part of routine consultations or as part of well woman and well man clinics and geriatric screening. This requires that the primary health care team meets regularly to discuss policy and specific patients, giving trainees an important opportunity to observe the trust and teamwork between all workers in the practice. Indeed, it is this relationship that gives a practice its atmosphere and will colour all the trainee's experience and memories from his time in the practice. If a trainee cannot work satisfactorily with the district nurses or has no concept of the role and uses of a health visitor who hope the trainee? If the receptionists are unable to discuss problems with the doctors or the doctors are unable to resolve conflicts between themselves this can have a lasting influence on a trainee's attitude.

The staff reimbursement scheme means that no practice has an excuse for poor secretarial back up. Trainees need to learn to delegate and work well with ancillary staff of all grades. Ancillary staff for their part have a large role in teaching a trainee about staff relations; staff management may be one of the most demanding and time consuming activities of a principal.

The physical environment of a practice is also important. Although I would not regard it as axiomatic, it is nevertheless important that certain standards are sought if not achieved. I would argue, for example, that all trainees should expect to have their own consulting room, a quiet room for journal reading and tutorials, and access to a nurses' treatment room that is properly equipped and staffed.

Electrocardiographs, peak flow meters, and proper lever scales are now accepted as usual, but should computers also be expected? Perhaps they will be in 10 years' time when we have learnt to apply them effectively. Good clinical care requires good record keeping, and this means not just effective medical records but also methods of identifying groups of patients by sex, age, or disease. Many practices installed manual age-sex registers to please committees selecting trainees, but these are now gathering dust, unused and unwanted. Thus possession of management tools is not sufficient: the trainee must also be able to use them. The ideal is a practice in which the trainee is able to run a disease register in a notebook and get better value from it than from an expensive and time consuming computer. There is little value in making demands for equipment if the need is ignored, the skill lacking, and the staff weak. More important is the engendering of an intellectual environment where clinical and organisational tools are constantly being evaluated and applied when appropriate. Again I return to the attitudes and abilities of the people in the practice.

A good training practice is exactly that—namely, one in which all partners participate in training. Tutorials should be shared and "coffee time" tutoring a group effort. When the trainee is away on holiday the tray on limbo, please, is not the last word for his mentor. The partnership should be sufficiently adapted

The counsel of perfection

If all this sounds impossibly woolly and idealistic then reflect that these points are exactly those that should be the core of trainers' workshops. We all, however, know of trainers who attend workshops who have no commitment to change. It is they who will scan this article for a check list of equipment and practice assets, hoping to buy the emblems of trainership.

We must start choosing and reassessing trainers on their attitudes and those of their practice. In this assessment we should look for training practices that are adept at using the available facilities to their full potential; self critically clinically and organisationally; prepared to change attitudes and methods in the face of logical argument; and aware of the wider world both medically and socially.

This is the counsel of perfection. Having started from minimum criteria, the search for reasonable expectations has led me to an exposition of the perfection we all should seek. But is this not just the process that the trainee should be encouraged to undergo? If the future of general practice is to be ensured through training then trainees must be shown where present day standards have failed and the power of critical analysis necessary to improve care wherever they may end up practising. Put simply, my minimum standard in any practice, but specifically in a training practice, is the commitment, both in theory and in practice, to improving patient care.

Diary of Urban Marks: 1880-1940

After Colclough I obtained from an agency in London, where I interviewed the man in question, an Australian who was a qualified chemist. He was a married man with two children and had come to England to qualify. At our interview I gave him to understand that he would have to work as a chemist in a practice as a buy out. He indicated that that was just what he wanted because he wanted to crowd as much experience into the 12 months which he guaranteed to stay with me. I obtained rooms for him within a stone's throw of this place. One day the family came down and that night of course went to bed. On the following morning the Australian went for me and left. I was very sorry for him and regretted that for the time being he and the family should go to the Mumbles to live.

On the Thursday of that week, he did not come up to the surgery and when he arrived on the following morning I asked him why. He said that it was such a fine afternoon he had taken his family on to Brecklet Point. I told him that his first duty was to me and that there were no holidays going. It was the first to have them. He disagreed and said that his first duty was to his family. He then said that it was his intention to take every Thursday afternoon and every Sunday off. In Australia the doctors did not work at all hours and he did not see why he should do so here. I could see that argument was useless and gave him a week's notice. That night when he went to the Mumbles he was last in Swansea. He went off on the following day and did not even ask me for payment. If he had done so there would have been none forthcoming as no doubt he surmised. What because of him I do not know nor care.

It was summer holiday time at this period and I was rather in a quandary for a focus as I expected my assistant would be available to carry on during my absence. By chance I heard that a man called William Henry Thomas was available. This man lived at Gorseion and to that place I hired myself. Thomas agreed to come here and was here for five years, first as assistant and then as a partner. We have been very happy together, chiefly I think because we are diametrically opposites of one another. This being so, those who know me will be able to gather some of Thomas's characteristics.