PRACTICE OBSERVED

GPs and Their Staff

Recruiting surgery staff

NORMAN ELLIS

Good recruitment and selection procedures can improve the running of your practice—for example, by reducing staff turnover. If you choose the right staff they are likely to stay with you and give good and loyal service. If you pick the wrong people they will leave voluntarily when they find more suitable employment, leave involuntarily when you decide they are not suited to the job, or you may even put up with unsatisfactory or indifferent standards of work.

Unlike large organisations the general practitioner cannot be expected to devote sizable resources to recruiting and training new staff. But the general practitioner experiences more acute difficulties than the large organisation if the staff he recruits prove to be unsatisfactory. Strong personal ties can develop among a small group of staff and any disciplinary action (which can ultimately lead to a dismissal) is often more difficult to take. It is only too common to find a doctor tolerating a poor level of performance from his staff simply because he cannot face the unpleasant and difficult task of correcting the problem.

Although the time spent on recruiting and training new staff may seem costly, it is often less costly in the long run than the resources that may be wasted when staff prove to be ill suited to their work. To neglect these matters almost always stores up trouble for the future.

Too often when a general practitioner is faced with staffing difficulties (which may even involve a threat of legal action) the roots of these lie in his failure to recruit the right staff in the first instance and to provide them with the training they require. These shortcomings may be compounded by an innate reluctance to manage. Early difficulties are left uncorrected, and unsatisfactory performance and working habits are allowed to persist

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and are thus tolerated by all concerned. The general practitioner's failure to act in these circumstances is often interpreted (quite understandably) as evidence of his tolerance of indifferent standards of performance and unsatisfactory working practices.

When a vacancy occurs

When you have a vacancy it is essential to consider whether the vacancy really needs to be filled, and, if so, whether the content of the job has changed. (Have there been any changes in work pattern, technology—for example, computerisation—or organisation since it was last filled?) You should also consider whether there are likely to be future changes in the job which require additional or different skills. A good way of assuring yourself that the job has been thoroughly reviewed is to prepare a "job description."

It may seem pedantic to write a detailed description of the job. Is it not sufficient simply to give the job an accurate title? Unfortunately, there is no easy way of avoiding the task of preparing an adequate job description if you wish to put relations with your staff on a sound workable basis.

The job description should describe the tasks and responsibilities of the job:

(i) Main purpose of job: try to summarise this as briefly as possible. (If you cannot identify a main purpose the job may need to be reviewed.)

(ii) Main tasks of the job: try to use active verbs, such as "filling," "answering," and "helping" rather than less precise terms such as "deals with" or "in charge of."

(iii) Scope of the job: although the "main tasks" may describe what has to be done, they may not always indicate the job's scope or importance. Under this heading you may need to emphasise the degree of accuracy or precision required and the number of people supervised.

The length and detail of your job description will vary according to the job. But it is preferable to aim at providing a clear and

information over the phone or at the interview. The advantage of using an application form is that it is easier to compare like with like, thus helping with the initial sift of candidates. You, not the candidates, determine what information is included and the form may be a basis for the interview. The standard of completion may be a guide to the candidate's suitability, particularly if clerical skills are important to the job. But application forms do lengthen the selection process and add to your clerical and administrative costs.

Selecting the best candidate

For most vacancies you may want to receive written applications in advance of the interviews and to arrange a simple practical test. (It is common practice to test typing and shorthand skills.)

Your partners and you will need to decide who should be on the interviewing panel—if you have a practice administrator or manager you may wish him or her to participate in the selection of a receptionist. The extent to which the practice manager or administrator will participate in the selection will depend on the particular circumstances of your practice. In some practices the practice manager may carry out a preliminary sift of applications by a first interview, reducing a large number of candidates to a final shortlist. These shortlisted candidates are then asked back for a second interview with some of the partners. At the very least you should allow your practice administrator to express a view before a final decision is made. The likelihood of the new employee settling successfully into your practice depends to a great extent on the person who supervises the work and is responsible for seeing the new recruit is properly trained and made to feel welcome. If your practice administrator has helped in the selection of the new employee he or she will naturally feel more committed to him or her. Similarly, it is often advisable for the candidate to meet the rest of the staff before a decision is made.

References can be helpful but these should be used with care. They are often most useful for checking factual information such as details of previous jobs (length of service, absenteeism, time keeping, etc.). It is particularly important to check on the applicant's previous record of absenteeism and sickness. If you want an opinion on suitability for a specific job, a brief outline of the duties should be sent to the referee and a subsequent telephone conversation may be helpful.

The interview

Although most jobs are still filled by interview, doubts have been expressed about this method of selection. Despite its limitations, it is widely used and general practitioners will undoubtedly wish to use it to select their staff.

For your interview to be effective you need to do some preparation, and they will need to be conducted in an orderly and thorough manner. The interview need not be an overformal or elaborate exercise.

Three other points need to be remembered at the outset. Firstly, you should consider preparing a check list of the points to be raised. Secondly, you may inadvertently enter into contractual obligations (albeit verbal) either in reply to an unexpected question or by merely agreeing to the candidate's terms. Do leave an escape route by emphasising that the employment contract will be in writing and that it will cover all relevant matters. Thirdly, throughout the interview you should ensure that the job is described in terms of the duties of the candidate on grounds of race, colour, nationality (including citizenship), or ethnic or national origins. It is also unlawful for employers to discriminate on grounds of sex or against married persons. Discrimination is prohibited in recruitment and in re-

lation to existing employees. Employers with fewer than six employees are excluded under the Sex Discrimination Act (although this does not apply to discrimination by way of victimisation).

Your preparation should include the following:

- (1) Compare the personnel profile with what you already know about the candidate. Are there any areas of experience, or qualifications, for instance, which will need to be explored or clarified? For example, you may decide to test typing, shorthand, and audio skills, and also assess the clarity of handwriting.
- (2) Plan your questions. These should probe the candidate's knowledge, ability, and attitudes. Some questions should be aimed at a more general assessment of the candidate. In this area you may wish to explore in some detail the candidate's domestic and family commitments—for example, children, elderly relatives, and even pets. How extensive are these? Are they likely to take priority over his or her work, and how often is this likely to occur? The health record will need to be discussed and you may wish to seek the candidate's agreement to approach his or her general practitioner. Ease of travel to work can be important, together with flexibility in approach to working hours. Few practices can work with a rigid attitude to stopping at a fixed time when the bell goes. Finally, the candidate's motives for changing jobs or seeking employment, or both, are relevant.
- (3) If there is more than one interview allocate the subjects to be covered.
- (4) Provide an opportunity for the candidate to ask questions and anticipate the information needed to answer the most likely ones.
- (5) Be organised, allow enough time, avoid interruptions, and have someone available to show candidates to the cloakroom, waiting room, etc.

Poor interviews are usually caused by the interviewer being unprepared and unaware of how demanding interviewing can be. In these circumstances the interviewer may talk more than the interviewee and ask leading questions to which the answers are far too obvious. In addition, important aspects of the candidate's previous experience, qualifications, views, and attitudes may be left unexplored, so that a proper comparison of candidates cannot be made.

It is useful to have shown the candidate the job description beforehand and to have a copy of your contract of employment to hand during the interview. Do ask the candidate if he or she has any questions about the job description. Do not hesitate to mention any demanding and important aspects of the job. It is far better for the candidate to learn at this stage than later about any aspect of the job he or she may not like. It is also advisable to show the candidates around the surgery, letting them see what work has to be done, before asking them to commit themselves to the job.

After the interview

After each interview is completed write up notes on your impressions, recording any points strongly for or against the candidate. This will help you to make your final decision, particularly if others participate in the discussion. These notes will also help you to monitor the effectiveness and fairness of your procedures. Your reasons for appointing or not appointing a particular candidate may be important in case you are challenged—for example, under the sex discrimination or race relations legislation. (It may be worth retaining your notes to refer to if a further vacancy occurs.)

When you have taken your decision inform all the applicants of the outcome. (It cannot be emphasised too often that if you have doubt about the suitability of your preferred candidates do not hesitate to defer the appointment and seek new candidates.) Your letter offering the job should say the date on which

simple description. (See appendix for a specimen job description: this draws heavily on an original draft prepared by the Association of Medical Secretaries, Practice Administrators and Receptionists.)

The job description is important because it tells you what kind of person you need for the job. It may be used to build a profile of the type of person you would like to fill the post.

The profile of the person you need

The profile is prepared by devising a list of headings under which you can classify the attributes of the ideal candidate for your vacancy. You may prefer to draft your own headings; those in the table merely illustrate how this might be done.

Specimen profile of the person to be employed as a receptionist

Necessary	Desirable
Acceptable bearing and speech	Impact on other people
Ability to type, to operate FAX, telephone equipment, to use word processors and general office equipment	Pleasant manner, bearing, and speech
Ready grasp of a point	Qualifications and experience
	RSK II typing, previous experience of receptionist work
	Initiative
	Can assess priorities and make decisions quickly
	Memories
	Other commitments—for example, family and domestic—are such that they would not be a prior commitment. Able to work flexibly in an emergency and to do overtime during holidays, absences and (if short notice) sickness absences of other staff
	Adjustments
	Steady, self-reliant, good at maintaining a pleasant and reassuring relationship with patients and the efficient running of the practice
	Health record
	Good. In particular, there should be no previous record of illness that might lead to an absence of days

- (1) Impact on other people: physical appearance, speech, and manner.
- (2) Qualifications and experience: education, qualifications, previous work experience. Simple and obvious matters to be considered might include clarity of handwriting, typing, and audio and shorthand skills.
- (3) Ability to learn: speed of comprehension; ability to acquire new skills, etc.
- (4) Commitment: what goals does the candidate set for himself or herself? Does he or she pursue these with consistency and determination? How successful has he or she been in achieving them? In particular you should know whether the candidate is seeking work to widen his or her interests—for example, to get out of the house, to have a break from family commitments. Family commitments, if pressing or extensive, can understandably soon take priority over work. Sudden absences for these reasons can cause chaos among a small staff.
- (5) Personality: emotional stability; capacity to work under pressure and to deal with stress; is he or she likely to get on with your other staff, the doctors, and the patients? Another factor which employers in the health sector need to be aware of is its tendency to attract applicants who have a preoccupation with illness (particularly their own ailments).
- (6) Health record: in general you should be looking for a good health record. A small practice inevitably finds it more difficult to cope with frequent or long absences. (In particular you will

need to be cautious about any previous psychiatric illness that might lead to drug abuse.)

The characteristics identified as necessary from an analysis of your job description should then be entered against the appropriate heading. It is often helpful to enter two levels, indicating what you would be looking for in the ideal candidate, and what you regard as a minimum acceptable level to do the job satisfactorily. In addition, you should list any personal characteristics or circumstances which would definitely be unacceptable; for example, you would not wish to employ a receptionist anyone who had an abrasive manner.

An example of a completed profile based on the specimen job description is provided below. How much detail is included in the personnel profile will depend on the job, but not always with the level of the post; for example, a junior post can have important requirements under the heading "impact on other people."

If the personnel profile is used as a basis for your interviews it will remind you to be both realistic and systematic. But it must be remembered that there is nothing precise or scientific about a selection procedure. By being systematic you will help to reduce the margin of error. Ultimately you must decide which of the candidates is best suited to fill the job. If after completing the interviews you think that no candidate is suitable, do not hesitate to defer an appointment.

Finding suitable applicants

Having written the job description and the personnel profile, you now need to consider the best way of reaching the "target group" of potential candidates. One method that is often used by general practitioners is by word of mouth, sometimes from introductions made by other staff or even patients. This has obvious attractions; it costs nothing and it helps you to recruit those people from the immediate locality who may have ties of friendship or family with your present staff and the practice. But it may have the disadvantage of perpetuating the existing composition of your staff and it might even lead to allegations of unlawful discrimination. There is also the hidden danger of relaxing your critical faculties and subsequently departing from your carefully prepared personnel profile. It is far too easy to be drawn into appointing someone about whom you feel reassured simply because they have been personally recommended to you, without having evaluated him or her against your criteria of selection. If this happens and your new member of staff is subsequently found to be unsatisfactory, the already testing business of dismissal is compounded by the family and personal ties with your other staff.

Many general practitioners have to recruit staff from the area in which their surgeries are located. Sometimes they recruit staff from among their patients. The problems of confidentiality are obvious enough, and at times it may be friends and relatives who pose the greatest potential threat to confidentiality. It is sufficient to emphasise this problem and you should ensure that all staff, particularly new members of staff, are aware of the importance of maintaining absolute confidentiality and that any breach of confidentiality will be treated as a serious disciplinary matter.

Local schools, colleges, and career services can provide many candidates who may be suited for your post; but if you recruit from these sources you will need to pay extra attention to your arrangements for training new staff. The local newspaper is often the most consistently reliable method of finding candidates, though it can be costly.

Application forms

You may choose between using a standard application form, asking for letters of application or simply taking down informa-

employment starts and cover the main headings of the contract. It should also refer to the employment contract which will be issued after the employee has started work.

Benefits of good recruitment procedures

Good recruitment and selection procedures are likely to provide you with the right people for your jobs. Your practice administrator or manager should participate in the recruitment. He or she will have to work with the person who is selected and probably play a major part in the training of the new member of staff.

Before you interview any candidates it is essential to analyse the job to be filled and to consider what type of person would be capable of filling it. By completing these tasks beforehand you can be more assured of fitting the right person into the right job.

Finally, having put this effort into the recruitment and selection of staff, you must endeavour to ensure that they are properly trained to do the job. Training is especially important if your new recruit is a school leaver or a person returning to work after a period away from it. (You may wish to plan for a period of overlap. If the staff are not using its full "quota" of ancillary staff a trainer could overlap with the present job occupant and the practice could receive its 70% reimbursement.)

I am grateful to Dr John Ball and Dr Ewen Bramwell for their advice. I am, of course, responsible for any omissions or errors. This article provides only a general guide to the provisions of existing legislation. It does not offer a definitive statement of law.

Practice Research

Evaluation of quality of contents of general practice records

S J JACHUCK, P PRICE, C L BOUND

Abstract

The quality of contents of general practice records was assessed by retrieving clinical information pertaining to hypertension in 171 consecutive records, and the quality of communication storage was assessed by seeking evidence of tuberculin skin tests or BCG vaccination, or both, in 298 consecutive records.

There was no mention of urine analysis and blood test results in 43.3% and no record of fundal examination in 81.4% of the records of patients with hypertension.

Electrocardiography was performed in 67.8% and chest x ray examination was done in 65.5% of these patients. These observations have importance for patient care, education, and research.

The information regarding tuberculin skin test or BCG immunisation, or both, was not available in 78% of the records. Reassessment of the individuals, however, showed that 89% of the studied population had had the test or vaccination, or both. There was thus a deficiency in communication and storage.

Introduction

The importance and the need for a system collecting, analysing, and feeding back information has been recognised.¹ Despite our increasing awareness of the importance of high standards of consistency and reliability in initiating and maintaining patient records, the ability to create and interpret records is rarely tested.²

The problem oriented medical records and tagging have

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been shown to improve records,¹ but these only organised clinical problems and the chronology of events. A change to the A4 system has been described as a possibility of rectifying the present structure of primary care records, but the benefit of this system is in the storing of letters, which affects only 10 to 15% of records in most practices.²

Medical records are an important documentation of clinical information, an essential educational tool, and an invaluable legal document. Improving general practice records is one of the priorities for developing the practice and education of primary care. The improvement should affect not only the structure but also the quality of contents.

We describe our experience in evaluating the quality of recorded consultations as well as the quality of stored communication.

Methods

The existing general practice records are far from satisfactory and even the basic data cannot be easily retrieved.^{3,4} We assessed major components of the records to evaluate the deficiencies. The contents of practice records were divided into two major components: practice records and communications. The quality of records was assessed by (a) retrieving clinical information pertaining to hypertension in 171 consecutive records to evaluate the quality of recorded consultation; and (b) seeking evidence of hypertension in a general practice or both, in 298 consecutive records to evaluate the quality of communication storage.

Quality of recorded consultation.—Hypertension has been used to exemplify the importance of medical records in screening and the performance of doctors.^{5,6} A retrospective study of 171 consecutive records of patients with controlled hypertension in a general practice was undertaken to assess the quality of clinical contents of practice records. We looked for the details of fundal examination, urine analysis, blood tests (haemoglobin, full blood count, and concentrations of blood urea, serum creatinine, and serum electrolytes), chest x ray examination, intravenous pyelogram, and electrocardiography (table 1).

TABLE 1—Results of the clinical examination and diagnostic investigation in 171 patients with hypertension

Evaluation	Information available		Information not available	
	No.	%	No.	%
Fundal examination	66	38.6	105	61.4
Urine	97	56.7	74	43.3
Blood	107	62.5	64	37.5
Chest x ray examination	112	65.5	59	34.5
Intravenous pyelogram	100	58.5	71	41.5
Electrocardiogram	116	67.8	55	32.2

Communication storage.—Tuberculosis is still one of the commonest communicable diseases in Britain, and the disease is four times more common in individuals who are tuberculin-negative.^{7,8} Since the introduction of BCG vaccination in 1950 the school health service screens children after 11 years of age and the results are expected to be stored in the general practice records. We examined 298 consecutive records of individuals born between 1940 and 1970 for evidence of immunisation to evaluate the quality of communication storage. Subsequently, the individual patients were examined for evidence of BCG vaccinations (table II).

Discussion

The Ministry of Health states that "The clinical record should contain all information that would normally be considered by general practitioners as necessary both to the doctor and to the other practitioners who may subsequently be responsible for the care of the patient to enable proper and necessary treatment to be given. This information should be of such a nature as to help in reviewing the progress of the case or likely to be of help on some future occasion."⁹

TABLE II—Analysis of general practice records for information pertaining to tuberculosis

Year of birth	No in sample group	Information not available	Information available
1940-50	133	118	15
1951-60	110	84	26
1961-70	55	46	9

The review of records of patients with hypertension showed that there was no mention of fundal examination in 61.4%, and no documentation of urine analysis and blood tests in 43.3% of the records. These clinical observations reflect on the cause and effect of the disease process. Both these assessments are easy and inexpensive, but invaluable. More patients had electrocardiography (67.8%) and chest x ray examinations (65.5%). The absence of such basic data reflects not only on the quality of the record, but also on the importance of such information in patient care, education, and research. It is difficult to comment on the performance of the clinician because "not recorded" did not necessarily imply "not done."

The deficiencies in the recording of clinical examinations have been claimed to be due to technique, omission, detection, interpretation, and recording.¹⁰ Thus the quality of clinical contents depends on the ability of the clinician to detect objectively the important observations after detection, provided the clinician has appreciated the value of medical records.

The clinician's performance accounts for 94% of the deficiencies in the clinical contents, and the remaining 6% is some lack of factual knowledge.¹¹ The quality of clinical consultations was better with structured records.¹² It is difficult to implement such systems in daily consultations in general practice. A well rehearsed flow chart, however, might improve not only the quality of patient care, but also the quality of the recorded consultation. A computer playing the role of a flow chart might be used to modify or enhance the record of consultation. The single most important factor in improving the recorded consultation is the motivation of the clinician to improve the quality of the document.

The information regarding tuberculin testing and BCG immunisation was not available in 78% of the records. Similar deficiencies were also reported concerning tuberculin vaccinations in school, and it was thought to be due to non-compliance with a vaccination programme because of a high mobility of the community.¹³

The reassessment of the individuals in our study showed that 89% of the studied population did receive the BCG vaccination or tuberculin tests, or both. This exemplifies the deficiencies in communication and storage. It is reassuring to observe that the deficiencies are being progressively rectified. Information we sought was still lacking in 56% of the records for the past decade.

The factors found that contributed to inadequate records were compared with our parents' homes, of course. We visit our parents a lot, and Mary's sister and her children are nearby, too, so we shall have our babies playing together, I hope.

- (1) Inconsistency in the structure and contents of the records. Indiscriminate designing of individual record systems and new cards, which fragments storage and causes difficulty in retrieval.
- (2) Lack of interest and motivation to promote uniformity of the record and improve the quality.
- (3) Destruction of medical records by the family practitioner committee, lost records, and indiscriminate "pruning" by the practitioners.
- (4) The existing structure of the general practice records.¹⁴
- (5) Factual knowledge—difficult to measure.¹⁵
- (6) The consulting time available.¹⁶

Conclusion

The quality of contents of the existing general practice records is unsatisfactory for medicolegal, educational, epi-

That is another thing about him I find irritating—the constant repetition of many and inappropriate quotations. Shelley's *Ode to the West Wind* has nothing to do with the case. Yet, there is—it's dragged in. Thus almost anybody's sentence will be capped by something out of *Hamlet* or *Macbeth* for no better reason than that he happened to study them for School Certificate and presumably had some vestige of a memory in those ancient days. Wynford Vaughan Thomas suffered from the same disease and admits this in his autobiography *Trust to Talk*. "One of the byproducts of the sort of education I received is a mind loaded with quotations that float up unbidden at all occasions." Well, our jocular parent and Vaughan Thomas both went to Oxford University. Enough said. I always thought they should have stuck to Latin and Greek and not meddled in medicine and useful things like that.

He may get his comeuppance one day, but he is so old that the other partners don't feel it's up to them to tell him. Perhaps one of the members of staff will do it for us politely.

We are having a lot of trouble these days with people parking

in our private surgery car park. The surgery is very convenient for the shops and where else can they leave their cars when they go shopping? The town is all double yellow lines or parking tickets. When the new Safeway supermarket is built just 100 yards down the road I expect we will be even more popular. Even now the district nurse has to queue sometimes before she can get her car in. Well, last Saturday our senior partner (I might as well admit he's the one I am on about) got quite paranoid and frantic and started rushing around all the parked cars sticking messages under their windscreen wipers. "This is a private car park. Please do not park here." He did have a point. There wasn't a surgery at midday on Saturday, so all those cars must have been trespassing. On Monday morning our deputy manager brought one of the notes back with a smile and a little message she had written underneath. The message said: "I know, Dr Nicol, I work here! Love Janet." She didn't half make me feel an idiot.

(Accepted 24 May 1984)

Life Changes

Getting married

CYRIL GILL

Letter from John

My wife and I had had other relationships before, but nothing as serious. Mary is different from any other girl I had met before. We had known each other for quite a time when we went to meet her parents. I got on very well with her father, who showed me round his garden. I could see how he enjoyed it. Her mother is still very young and full of energy, and I can see what Mary will be like one day. Then Mary came to my mother (my father died) and they understood each other very well. It was then that we felt sure of each other. I lived with my mother before, and after we married we lived there for a few weeks till our place was ready. It seemed strange to be with Mary in my mother's house. Mary did not like living there, she told me later. We were happy to move into our present flat, though it is rather poor compared with our parents' homes, of course. We visit our parents a lot, and Mary's sister and her children are nearby, too, so we shall have our babies playing together, I hope.

Mary is a teacher and was keen to go on working a little longer for the work and the money, but now she is pregnant. She did not like to take the contraceptive pill and would not hear of the fitted coil, so she used the Dutch cap. I am quite happy she is pregnant. She can catch up the work later, and my job is secure. We are quite frugal, and we should be able to manage the baby expenses. Sometimes Mary looks worried about this and I do not like to see her worrying.

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The only argument that we have had so far was when I took an extra day off at the end of a cold. Everyone does this, including the manager, but Mary does not approve. I cannot quite believe that I am going to be a father—marriage has broadened my horizons enormously. I asked Mary if she wanted to add anything, she has made a few comments, says she agrees, and has nothing else to add.

Doctor's comment

The couple that wrote this letter are not my patients, they are friends of friends, and it is safe for me to build fantasies from this material and to discuss them as though they were my patients. I have read the letter through several times and I think that I can build a picture about them that is similar to the one I would build from the ordinary content of general practice. I don't really actually have used this yet since they sound happy enough. We do not run premarital clinics in general practice, but we keep an open ear and respond to any distress that we pick up. Mary has attended a doctor for conception, and this might have given a good picture of her and of the type of troubles she might meet. Since getting married they will be getting a new general practitioner, and he will probably be doing the ante-natal care. This is also an excellent opportunity for help to be given.

John will probably not have seen a doctor for some years. In general practice we see more women than men. The vagina and pelvis carry various sexual and emotional problems, and the baby, and women are also more ready to share their thoughts and fears with doctors. Men do not often need to show their genitals to doctors, and it is pride that keeps our feelings buttoned up, too. What John says about their contraception

demological, and research purposes. It is essential that the profession outlines to the health authority a design for records and communication to produce a meaningful documentation of relevant clinical information pertaining to patients, which in turn will preserve and promote primary care.

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(Accepted 7 March 1984)

What Annoys Me Most

Facetious doctors

H G NICOL

One of our partners has a problem. At times his manner can be jocular, or even facetious. He'll try it on anywhere, even in the surgery, of all places. We will have to bring it up in one of our practice meetings pretty soon. If you look "jocular" up in the *Shorter Oxford* or in *Webster's* you will find "Full of jokes, sportive, waggish, playful, given to pleasantry or levity," which sounds harmless enough, but everybody knows that semantic shifts are always taking place in the meaning of words, and when they shift they can only go in one direction—downwards. Shakespeare's "presently" now means "any old time," for example. There is nothing in the dictionary which quite conveys the irritating tiresomeness of a facetious doctor. Medicine is not funny—it is a matter of life and death as often as not, so jokes should not be made about it. That's the real point I want to make. And yet it seems he can't help it. He'll see something funny in a situation and out will come some absurd persiflage, as quick as a conditioned reflex.

When Mrs Moss last came to the surgery with her three little Mosses he surveyed them as they crowded in, more than half filling the tiny consulting room, and said "Ah, a gathering of mosses." He would have liked to throw in an allusion to rolling stones (he's a simple chap at heart) but it didn't come, and anyway it was not strictly relevant. Then he chuckled to himself, obviously rather pleased with his gratuitous witicism, threw down his pen, and turned on Mrs Moss his most attractive smile. She returned it stonily. "We've come about Peter's cough," she said. Perhaps she had heard it before.

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may mure about their relationship, and the sex life which mirrors it. She refused the contraceptive pill and the intrauterine device. She probably dislikes letting doctors invade her body with chemicals and probes and understands, and still less, the idea of letting a doctor control her body and what happens to it by inserting an intrauterine device. John does not mention the possibility of a sheath. He takes his cue from her, and she prefers to control and manage contraception herself, with a device that she can put in (or not put in?) when she pleases. John does not blame her for getting pregnant too soon, nor does he blame himself. He takes life rather for granted, I guess, with a secure job (he is obviously not ambitious), and he thinks about money only when he reads the anxiety in his wife's face. (He does not like that!)

Fitting in to the older generation is very important to him, and he uses the rather stilted expression that marriage has "broadened his horizons," suggesting that it is not very real yet, though he is aware of the need to grow up in some direction. He "gets on well" with his father in law, but Mary and his mother "understood" each other very well. I suspect a polite deal here, with the reins being passed from one woman to the other.

Why did Mary get pregnant too soon? I suppose a correctly fitting cap sometimes has a genuine failure. I doubt if Mary would be incompetent, and it does not sound as though John has knocked it out of place. Perhaps she had a partly unconscious wish to get pregnant when she did, which may be jogged her arm as she was inserting the cap. If so, what were the reasons? She was not trying to get rehoused by the council, and we get no hints that she had doubts about her ability to conceive, but I do not know her age and she might perhaps be jealous of her sister's children. There might be other anxieties or parental pressures, but perhaps she was partly motivated by a desire to make John more responsible. It looks as though Mary is in the driving seat in this marriage, and John is more like the passenger, though quite sensitive and aware of this. There is nothing wrong with this of course, but it gives one ideas about the possible troubles that might arise. Mary's previous general practitioner may have given her advice on contraception and may have known her parents, too. If she had had problems with boyfriends, or stress over her work, the general practitioner is the obvious person for her to turn to. It sounds as though her father is gentle and passive like John, and she and her mother are both more lively. Mary will probably have competed with men in her work, and possibly she feels antagonistic to exciting and powerful men. She married someone nice and gentle like father, but a little irresponsible, and she tries to correct him. This might lead to troubles later.

What about John? He describes embarrassment at using the family home as a bridal chamber. I guess he is rather too close to his mother to be comfortable about this, and it could be inhibiting. Some young men enjoy sex while it is good fun and competitive and free from responsibility, but marriage puts a respectable rubber stamp on it all, and may remind John of his parents' marriage too. Bringing his wife to his mother's home might have aggravated this. Now the responsibilities of becoming a father may be seen as an added burden on him, which could lead to impotence. Mary might not mind this during the pregnancy since they could both pretend that they were afraid of damaging the baby by having intercourse, but as her body changes and her thoughts turn to the baby he might be tempted to "settlement" elsewhere.

I hope that I have been too far too imaginative with the material given. I have deliberately let myself be carried away. In practice I would of course wait for them to bring their distress to me. But suppose that their marriage had reached breaking point in the way that I have hinted—how could a general practitioner help?

If they had received a bad model of marriage from their parents they might struggle for years to help. "Prevalent might well repeat their mistakes. Their parents' marriages sound good, however, and I expect these models, and the responsibility

for the baby, will make them seek help if they need it. They might need referral for marital therapy, but this could be a long hard struggle, and if successful they would need to regain their autonomy and freedom. With such luck, their desire to stay together will be matched by a desire to change to meet the situation and sufficient skill to do most of the work themselves. John even mentions such ideas—broadening horizons—and in this case the lightest touch may help them.

Doctors often feel under pressure to do something active or clever, but here it would be more useful to be available to whichever one of them wanted to talk. In listening and encouraging the patient to talk the general practitioner may help the patient to see the problems more clearly, and they may then be able to discuss them with each other, or perhaps come to the general practitioner together once or twice. Many general practitioners who give such interviews, perhaps with a view to referral for marital therapy, have then found that the couple need nothing further. The intimacy of the general practitioner's work leads to a doctor-patient relationship that may give a hint of what goes on outside the surgery. I think that Mary might be inclined to do battle with her doctor, first about contraceptives (she would not hear of the fitted coil) and now perhaps about the management of the pregnancy. If so, then the way that the general practitioner handles this and responds to her may be important in enabling her to use him if she troubles again, and in giving him an idea about the nature of the trouble, too.

John might go to his doctor for a certificate if he had been away from work with his cold. This is often an irritating request, and he might get a certificate tossed to him by a disgruntled doctor, or he might be dismissed with an argument. Whether he gets the certificate or not the doctor might take an interest in him, even if it is only to find out whether a certificate is justified or not. The doctor's doubts may match his own, and this might help him to clarify the disagreement that he had with Mary about the extra day off. General practice contains trivia of this sort, but strong together over several years they may become more important than is immediately obvious.

ONE HUNDRED YEARS AGO

It is good to know that twenty thousand of the men employed on railways in the United Kingdom are "total abstainers, and workers in the cause of temperance reform." Or may we put the reflection in a slightly different form? As thus, it would be glad to have this knowledge, if there were not facts to show that a great many pointmen and many other servants who have been worked to the verge of physical and mental exhaustion, would have been all the better, and possibly not a few less lives saved, if they had had a moderate supply of stimulants, if, in short, they had been moderate drinkers, instead of what they were, total abstainers. We doubt whether in the whole history of railway accidents, from the first of the railways to the first of the accidents on railways to the incalculable of terrors personal among railway servants. We yield to none in our desire to preach and teach temperance—but temperance is not total abstinence. No man can be held to be temperate towards that which he utterly and relentlessly shuns, and which he almost—nearly altogether—spitefully contemns. The prophets of teetotalism must not suppose, because two or three prominent members of the medical profession have not only "sworn off," but committed themselves bodily to a crusade against all stimulants which happen to be intoxicating—when taken in excess—the whole profession is, in its certain judgment, prepared to applaud the teetotal movement. Like most other movements which have been pushed to an extreme, the temperance movement has done good, and the common-sense must ultimately prevail; and when it does it will be seen that wisdom consists in the wise use, not the abuse, of all the good things which nature has provided for us, in brief, moderation. (*British Medical Journal* 1884;ii:875.)