PRACTICE OBSERVED

Reflections on Practice

JCPTGP: from the other side of the fence

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Recent articles on the Joint Committee on Postgraduate Training for General Practice by two of its members sadly fail to quell the anxieties of many course organisers on this side of the fence. It is undeniably true that when mandatory vocational training came into effect in 1981 the joint committee was necessary to implement the Act. Whether or not there is still a need for it is open to debate, however.

It is hard to see how this august body with representations from almost every section of the medical profession regardless of direct concern with vocational training could claim any credit for monitoring the quality of training when there is neither a defined standard nor a means of implementing one. Perhaps the quality of training is now so high that these questions do not arise, but judging from the recent guidelines from the committee, and the experience of many course organisers, the standard of training is at best variable and at worst clearly unsatisfactory.

Rhetoric

It seems that the joint committee by and large has busied itself with issuing rhetorical guidelines, the implementation of which are left to the goodwill of the regional general practitioner subcommittees. Theoretically, this might seem a fine idea were it not for the fact that the regional subcommittees suffer from the same structural and ideological weaknesses as the committee. They are too large and too disjointed and represent too many conflicting views politically to have any chance of success; therefore, inertia, indecision, and political expediency tend to characterise their work. Indeed, there is growing disillusionment with the way that the joint committee has fulfilled its two main functions, as defined under the National Health Service Vocational Training Regulations. The first function —to issue certificates for prescribed or equivalent experience—is nothing more than a "rubber stamping" exercise, as shown by the recent statistics. Of 7000 doctors applying for the certificate in 1984, only 0·2% failed to obtain it. Therefore, I wonder if this administrative and seemingly non-discriminatory function of the joint committee could not be carried out more economically locally. This would obviate the need for a great deal of bureaucratic documentation which is now a feature of the system.

Assessment

The second function of the joint committee is to assess the quality of training as measured by visits to practices, joint visits to hospital posts, and of course the "paper approval system." The visit to assess one practice, as demonstrated by the "What sort of doctor" exercise,[1] generally takes a whole day, at the end of which there is still much doubt about its validity and reliability. The visiting team from the joint committee is supposed to assess a whole scheme, two or three or more training practices, and meet and exchange views with a string of consultants, trainers, and trainees in one day. Can the committee really believe that this so called inspection, once every two years (usually less often) is more than a cosmetic, expensive, and time wasting exercise of no real consequence or value? For example, my own large scheme of 28 trainees, 11 trainers, and countless hospital posts was inspected by three kind and tolerant colleagues in six hours. They hardly had time to think before they were pushed to another rendezvous to keep to a ridiculous time schedule which had been agreed in advance between the region and the joint committee. In three days these three people had to endure travelling many miles to assess three schemes of contrasting styles and structure and their various component parts and then produce a comprehensive report with earth shattering, mind boggling, and valuable recommendations.

I cannot believe that anybody who has the slightest notion of the complexities of the system of general practice training would be foolhardy enough to dream of such an impossible mission. Even the one possibly useful benefit of these whirlwind tours, which might be to pressurise some reluctant consultant colleagues (who may be slightly more impressed by the joint committee than by a local course organiser) in to making their posts more relevant to the requirements of vocational training, is rarely realised. There is usually a delay of several months in approving and publishing the report and much confidentiality mysteriously surrounds its distribution. Usually the regional adviser is privileged to see the report in full, and then, depending on his generosity, the course organiser and trainers concerned may be allowed a glimpse of excerpts. Surely the report and all its details should be available to everybody concerned for discussion and possible action.

It seems that the joint committee has never come to grips with its main function, which is to assess the quality of training. This is inevitable since a political committee as widely based as it is can do little but to hope for compromise and consensus, which at this stage of vocational training leaves a lot to be desired. I believe that there is little need for the joint committee to continue. It has outlived its usefulness. The Royal College of General Practitioners should be given the overall responsibility of setting standards of training. After all, that is what happens in other specialties of the profession. The membership examination should be the tool to assess vocational training. In the absence of a nationally agreed core curriculum of training the examination may be criticised for being irrelevant to what is being taught, but once we have a national syllabus (one of the tasks facing the Association of Course Organisers) I believe that the examination can be modified without much difficulty to meet the challenge.

There is an urgent need to define nationally agreed standards of training for the schemes, training practices, and, more pertinently, the hospital posts used for general practice training. The time has come to move from a mere consideration of quantity (having enough jobs and schemes) to that of quality. The joint committee is no longer the instrument that can best serve this purpose.

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Practice Research

Irritable urethral syndrome: follow up study in general practice

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Abstract

Two years after a microbiological study of the urethral syndrome 25 of 31 women had had further symptoms, but only two had sought medical help for their symptoms in the year after the study. Analysis of patients' records showed that women with the urethral syndrome had higher consultation and sterilisation rates and more psychosomatic symptoms and relationship problems than matched control patients. Using the Nottingham health profile women with the urethral syndrome were more likely to mention that health problems affected their sex lives and were more likely to see themselves as having health problems than control patients.

Women who have the urethral syndrome are a considerable drain on the doctor's time, and management needs to be directed towards the anxious patient who makes such demands. Seeing the condition as the "irritable urethral syndrome" may help both doctor and patient to recognise the psychosomatic aspect of the problem.

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Introduction

While studying the urethral syndrome along traditional microbiological lines we noticed that it was a short self limiting illness and that general practitioners were able to predict, before a midstream urine specimen was analysed, which patients had conventional urinary tract infection and which had the urethral syndrome as evidenced by their antibiotic prescribing. Doctors seemed to be able to distinguish between the two conditions from the severity of dysuria and on the psychological make up of the patient. Patients with the urethral syndrome were more likely to present with frequency only than women with urinary tract infection and also presented more psychological illness to their general practitioners than the women with urinary tract infection or control patients matched for age and sex. Furthermore, patients who suffered from the urethral syndrome had made regular visits to the doctor before the study with urinary symptoms, but in a median observation period of 12 months after the study none had consulted with the urethral syndrome.

We were sufficiently puzzled by these observations to investigate whether something had happened as a result of the research encounter(s) which altered the subsequent pattern of consulting the doctor for urinary problems in women with the urethral syndrome. The investigation was designed to measure: (*a*) if these patients had any further urinary symptoms; (*b*) if they had symptoms that they were now able to manage on their own; (*c*) if they had had symptoms but had been reassured by the time spent and the thoroughness of the investigation; and (*d*) if they had had symptoms but the investigations frightened them away.

We also wondered if the fall off in consultations for urinary

symptoms was more generalised or if patients had focused on another part or parts of their bodies and thus began to present with other psychosomatic symptoms.

Method

In the original study there were 39 women with the urethral syndrome and 40 women with urinary tract infection.[1] Forty age matched control patients were also randomly chosen from the practice population but three had to be excluded because they had already presented with the urethral syndrome. At that time analysis of data was carried out only on the patients with the two disorders of urethral syndrome and urinary infection. In this follow up study we used the original controls because their outcomes would be less predictable than those of patients with urinary tract infection, and there is overlap between the patients with the two disorders.

Of the original group with the urethral syndrome (n = 39), 32 were interviewed, five having moved away and two refusing to be interviewed. Of the control group (n = 37), 26 were interviewed, nine having moved away, one having refused, and one being untraceable. There were no significant differences between the two groups with regard to age, marital state, single parenthood, or social class.

A pilot project was initially carried out on eight patients in the original study sample (n = 39) using in depth interviewing to explore the women's perceptions of their symptoms, the possible causes, the problems it created in their lives, and their reactions to the research investigations. For the main project the remaining patients in the original study sample (n = 31) and all the original random sample of control patients matched for age and sex from the practice population (n = 40) were sent a letter explaining the purpose of the study and requesting permission to visit. Both groups were interviewed at home (RP) using a semistructured schedule. The interview was tape-recorded for transcription afterwards.

The interview with the patients in the original study sample covered attitudes to the investigations carried out, their subsequent experience of symptoms, and any action taken. Both study and control groups were asked about past experience of lower urinary tract symptoms and their views about past management. Both groups were given the Nottingham health profile, which is a two part self administered questionnaire designed to measure perceived health problems and the extent to which such problems affect normal activities. Part I measures six health problems: physical mobility, pain, sleep, energy, emotional reactions, and social isolation. Part II measures seven aspects of daily life that are affected by health: work, looking after the home, social life, home life, sex life, interests and hobbies, and holidays.[2]

The patient records of both women with the urethral syndrome and control patients were then reviewed blindly (JES), and the following data were extracted for the two years after the original study: (*i*) demographic details and consultation rate; (*ii*) lower urinary tract symptoms; (*iii*) psychosomatic markers (recurrent abdominal pain, a diagnosis of "anxiety" or "depression" recorded in the case notes, headache, backache, and tiredness of unexplained origin; (*iv*) tranquiliser prescription; (*v*) new menstrual problems; (*vi*) relationship problems; and (*vii*) contraception. Analysis of patients' records was performed using χ^2 and the health profile was analysed using non-parametric statistics.[3]

Results

Interviews—At interview up to two years later 25 (78%) of the group with the urethral syndrome claimed to have had symptoms since the original study. Of these, 15 (60%) said that they were coping or putting up with the symptoms, four were self treating with antibiotics left over from previous episodes, three seemed to have vaginal soreness or discharge, two had gone straight back to the doctor and had proved urinary tract infection, and one was disillusioned with her care. Twenty four (75%) of the 32 women with the urethral syndrome said that they "didn't mind" the research investigations, whereas eight (25%) had found them positively helpful. Only the 27 in the main project were systematically asked about attitudes to the management of their urinary problems. Twelve (44%) were happy with the study and long term management of their problems, but 15 (56%) had reservations about their overall management for example:

> "Well you always get an answer—most of the time they'll do a water test—sometimes they say just drink plenty you know, but you really don't feel satisfied that you've found out that it is *definitely* what you've gone over to the doctors' thinking it is . . . you don't feel like the question has been answered."

Analysis of patients' records—Twenty (77%) of the control patients admitted to ever having had symptoms, and of this group, 14 (70%) had sought medical help. They made a clear distinction between "cystitis" (frequency and dysuria) and frequency only, claiming to need medical help when they had "cystitis." In the six months before the original study 81 (97%) of the women with the urethral syndrome had presented with lower urinary tract symptoms, but none of the controls had presented. In the year after the study only two (6%) of the women with the urethral syndrome presented with urinary symptoms and both of these had urinary tract infection; two controls also had this during this year. In the second year after the study 16 (50%) of the group with urethral syndrome presented with lower urinary tract symptoms on 21 occasions. Nineteen midstream urine analyses were done: five were positive and 14 were negative for urinary tract infection. During that second year six (23%) control patients presented with urinary symptoms; all had urine analyses and five were positive and one was negative for urinary tract infection (table I). The women with the urethral syndrome had more psychosomatic and new menstrual problems than controls (tables II-IV). They favoured sterilisation as a method of contraception ($p = > 0·001$), had more relationship problems ($p = 0·01$), and consulted the doctor much more than control patients ($p = 0·0001$). Tranquiliser use was not significantly different in either group, perhaps because we are a low prescribing practice. There is little to suggest that the group with the urethral syndrome focused on another area of their bodies.

Health as perceived by patients—The Nottingham health profile was administered to both groups up to two years after the original research project. The women with the urethral syndrome scored significantly higher on the emotional reactions scale ($p = 0·02$), responding "yes" to such statements as: "things are getting me down", "I've forgotten what it's like to enjoy myself", and "I'm feeling on edge." There was a strong trend on the

TABLE I—*Women with the urethral syndrome (32) and control patients (26) presenting to their general practitioner with urinary symptoms before and after the original study*

	Six months before study		Year after study		Second year after study	
Urinary symptoms	Urethral syndrome	Controls	Urethral syndrome	Controls	Urethral syndrome	Controls
Frequency (F)	19				11 (1)†	1*
Dysuria (D)	6		2†		13	11
F and D	6		2†		4 (3)†	4†
None	1	26**	30	24	16	20

**$p < 0·001$ NS, *$p < 0·05$. †proven urinary tract infection.

TABLE II—*Women with urethral syndrome (32) and matched controls (26) presenting to their general practitioner with psychosomatic symptoms before and after the original study*

	Six months before study*		Year after study†		Second year after study‡	
	Urethral syndrome	Controls	Urethral syndrome	Controls	Urethral syndrome	Controls
Patients without symptoms	6	19	14	21	15	21
Patients with symptoms	26	7	18	5	17	5

*$\chi^2 = 20·68$, $p = < 0·001$; †$\chi^2 = 7·29$, $p = < 0·01$; ‡$\chi^2 = 7·39$, $p = < 0·01$

TABLE III—*Psychosomatic symptoms* presented to the general practitioner by 32 women with the urethral syndrome and 26 matched controls before and after the original study*

	Six months before study		Year after study		Second year after study	
Symptoms*	Urethral syndrome	Controls	Urethral syndrome	Controls	Urethral syndrome	Controls
Tired all the time	4	1	3	2	5	1
Abdominal pain	8	1	6		5	1
Headache	3	1	1			2
Backache	1	1	5	1	3	
Anxiety	15	1	9	1	8	2
Depression			1	2	2	

*Can have more than one

TABLE IV—*New menstrual problems as presented to the general practitioner in 32 women with the urethral syndrome and 26 controls before and after the original study*

	Six months before study*		Year after study†		Second year after study‡	
Menstrual problems	Urethral syndrome	Controls	Urethral syndrome	Controls	Urethral syndrome	Controls
None	24	24	23	25	24	23
Any	8	2	9	1	7	2
Dysmenorrhoea	5	1	6	1	6	1
Menorrhagia	2	1	2		1	1
Irregular periods	1		1			

*$\chi^2 = 4·08$, $p = < 0·05$; †$\chi^2 = 6·32$, $p = < 0·02$; ‡$\chi^2 = 3·24$, NS

energy scale ($p = < 0·07$), with the women with the urethral syndrome responding "yes" to such statements as: "I'm tired all the time", "everything is an effort"; and "I soon run out of energy." This group was significantly more likely to mention that health problems were affecting their sex lives than controls ($p = < 0·05$). Comparing high and low consulters in the syndrome group shows that those who had been to the doctor six or more times a year (n = 20) were significantly more likely than those who had been one to five times (n = 9) to see themselves as having problems as judged by the health profile (energy scale $p = 0·04$; pain $p = > 0·03$; mobility $p = > 0·02$).

Discussion

The original study began as a traditional microbiological investigation of the urethral syndrome, which, being negative, forced us to look for a broader explanation.[1] Follow up studies in medicine are traditionally confined to topics with easily measurable outcomes. The follow up study reported here was not planned as part of the original study, and we recognise that over a fifth of the original study groups were not interviewed, though analysis of the case notes for both consultation frequency and contents shows that the women with the urethral syndrome and the controls who were not interviewed conform to the patterns of their respective groups.

The results of this follow up study show that the original study merely showed an event in a long medical record. The women with the urethral syndrome are a high demand, anxious group who have reservations about their long term medical management. They tried to cope with their symptoms after the original study but went on visiting their general practitioner, often with other, sometimes ill defined, psychosomatic problems. They did not focus on a particular area of their bodies, though most of their symptoms were based in anxiety. Tranquiliser use was not appreciably greater in the group with the urethral syndrome compared with the controls, though it was so when compared with women who had urinary tract infection. Two years after the original study the Nottingham health profile detected differences in how the women with the urethral syndrome and control women see themselves. The former group did not feel healthy and felt that their health was interfering with their sex lives. This raises the possibility of psychosexual problems in their lives, and this needs to be further explored. The women with the urethral syndrome have more interpersonal difficulties and menstrual problems than controls, and many have been sterilised; they may have chosen sterilisation as a solution to these problems.

The urethral syndrome is a difficult condition to manage, and this makes those who suffer from it vulnerable to treatments and procedures that are inappropriate. Such women may be referred and have their urine and lower urinary tract investigated until both doctor and patient are frustrated and angry with lack of success. Because the syndrome mimics urinary tract infection doctors feel bound to exclude this. The patient may either get an antibiotic or have a midstream urine analysis at the initial consultation. This sets expectations of treatment success or of finding a cause, both of which are not fulfilled in the current management of the syadrome. Indeed, patients may be told only to ring the doctor's receptionist for the result and if positive a prescription will be left at reception. If the result is negative the doctor feels that he has discharged his duty, but the patient is left feeling confused. Such management would not be acceptable in the irritable bowel syndrome, yet there are many similarities between the two conditions. If doctors were to see the urethral syndrome as the "irritable urethral syndrome" and spend time explaining the condition to the patient there might be less dissatisfaction in both doctor and patient.[3]

Management of the syndrome in general practice needs to be directed towards the high demand, anxious patient. It requires doctors to think through the consequences of the midstream urine analysis. If the test is positive management is straightforward, if negative management becomes complex. Setting the urine analysis as the arbiter of the presence or absence of illness may be interpreted by the patient as a lie detector test. Once the test is failed distrust begins, and there is a need to incorporate a test that will be potentially negative into the management plan for each patient.

Asking doctors to follow a psychosocial management plan for an apparently clinical problem provokes clinical insecurity. "What if I miss something?" "Maybe we haven't looked hard enough for another organism?" "What if further research shows something else?" These are heartfelt dilemmas for doctors who want to help these patients. Doctors, however, may have to start by resolving such clinical insecurity within themselves and realising that searching for organisms alone to explain the patient's symptoms inhibits the understanding of the irritable urethral syndrome.

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100 YEARS AGO

It is a not unfrequent complaint on the part of the public that the charges of the druggists are so high, that their bills often mount up nearly as high as those of the medical men. To this the invariable reply is that the patient must be prepared to pay for the skill and accuracy required of the chemist in his work, over and above the value of the article of the drug supplied, which is often quite trifling. It is very desirable that such skill and accuracy should be at all times displayed by the members of the dispensing fraternity. But is this always the case? Apparently not. A few days ago, Dr. Edward Seaton and Mr. Otto Heymer presented to the Chelsea vestry the results of a joint inquiry undertaken by them last July, and prosecuted up to the present date, to ascertain the degree of accuracy which was observed in the dispensing of prescriptions, chiefly in their own parish. In all, fifty prescriptions were sent out, namely, thirty to chemists and druggests, fourteen to co-operative stores, two to "doctors' shops," and four to certain drug-companies. They decided to give a liberal margin for errors, and accordingly did not schedule any prescription as incorrectly made up if the chief constituents were within 10 per cent. of the amount ordered. According to this classification, no fewer than seventeen out of the fifty prescriptions were incorrectly dispensed. The limits of error were very wide indeed, for in one case the quantity of the drug supplied was less by 85 per cent. than that ordered, and in another, 57 per cent. more than had been ordered. The chemists and druggists pure and simple have come out of this ordeal with great credit, as in only two cases did the errors mount up so largely as to be scheduled, whilst "co-operative stores" figure on the black list three times, the "doctor's shop" once, and the "drug company" three times. Thus, to put it another way, 75 per cent. of the prescriptions dispensed by the latter class are untrustworthy, 50 per cent. of those from doctor's shops belong to the same category, whilst 20 per cent. of the prescriptions dispensed at the stores, and 6 per cent. of those at a regular druggist's, will also exceed the margin of error. The moral is obvious. (*British Medical Journal* 1886;**i**: 410.)