settings. Low uptake in hospital new entrant clinics we believe reflects administrative problems, notably people not receiving invitations for screening because they have already changed address, rather than low acceptability. We visited addresses of such people and found they had moved.

Acceptability in the settings we studied does not mean acceptability in every setting. Several respondents intimated that screening at the port of entry was unwelcome. This should be addressed with further qualitative work.

Mihas et al. cite several studies reporting uptake of screening for tuberculosis. High rates of uptake of a screening test may indicate acceptability but could also reflect coercion. Qualitative interview studies are therefore particularly useful when exploring acceptability as they provide an in-depth picture of recipients’ views. Mihas suggests that larger studies are better. Sample size in qualitative studies is generally governed by the principle of data saturation—ceasing sampling when new information or themes are no longer forthcoming from additional respondents.

Mihas is right to point out that we interviewed no one from Pakistan. It is possible that people from Pakistan might hold different views to the rest of the sample. On balance, this seems unlikely as we did interview nine patients from the Indian subcontinent with varying socioeconomic and religious backgrounds.

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Concerning: Generic outpatient referrals

Sirs,

Little has been published about generic referrals, and Taggarshe et al.1 provide useful data on why general practitioners (GPs) might prefer to refer to individual consultants rather than generically to hospital departments. I add some further comments, with a view from secondary care.

Many consultants take personal pride in trying to reduce their own waiting times. If a patient is referred to Dr X, then Dr X usually feels responsible, on receipt of the letter, to try and see the patient within an appropriate time. This may, with higher priority referrals, lead to more patients being squeezed into a clinic and a genuine reduction in waiting times. Consultants who feel a personal duty of care for patients referred to them by name will conversely feel less responsible for dealing with ‘Dear Colleague’ letters. This is analogous to home life, where most people are more likely to take notice of a letter arriving through their letterbox that is addressed personally than addressed ‘Dear Occupier’.

Furthermore, a consultant who has previously prided himself/herself on working hard to reduce waiting times in his/her clinics will see no great incentive in continuing this way if he/she is to be rewarded for reducing waiting times with a flood of ‘Dear Colleague’ referrals.

There is a feeling in secondary care that GPs are more likely to use ‘Dear Colleague’ referrals when the quality of referral is poorer. Perhaps the GP feels a little embarrassed at identifying a specific consultant to whom he/she is referring the patient in this situation. There is also an impression that the quality and quantity of information is poorer in ‘Dear Colleague’ letters than in named consultant referral letters. This does not help the consultant prioritizing the letter and of course does not help the patient.

Taggarshe et al.1 highlight good reasons why GPs often want specific consultants to see their patients. The insistence by primary care and secondary care trusts that GPs must make generic referrals is analogous to being connected to a telephone call centre when you want to speak personally to your own bank manager. Practising medicine does involve many personal components. Without a personal approach, I believe the GP–consultant partnership is weakened, and patients will lose out.

Reference

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