leaving one or more problems to another occasion if necessary.

Only when doctors have a better understanding of what they are trying to achieve at the beginning of every consultation will they more readily embrace those patients who bring written lists which actually facilitate agenda setting for the doctor. It is the teaching of appropriate research-based communication skills rather than the extension of the use of written lists that is the crucial message here.

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Quality of minor surgery in general practice

Sir,

The paper by Lowy and colleagues concerning minor surgery in general practice (August *Journal,* p.364) was an interesting examination of some of the issues concerning this subject. The emphasis of the study was the examination of quality before and after the expansion in surgery in general practice following the 1990 contract for general practitioners. However, the basis of quality was not effectively established and the results of the study illustrate one of the most worrying aspects of common practice.

Including only the clinical categories of warts, naevi, cysts, skin tags, benign tumours and basal cell carcinomas, the study yielded 720 specimens. From the results presented it is possible to calculate that 222 of these were sent for histological analysis (30.8% of specimens). In those specimens that were sent, comparison of the clinical and histological diagnoses revealed that an incorrect clinical diagnosis had been made by the general practitioner in 58.8% of cases in 1990 and 50.0% in 1991. What was the diagnosis in the 69.2% of specimens that were not sent for histology? In the case of benign tumours 72.4% were not sent for histology to confirm their benign identity; with a misdiagnosis rate of 50–59% this would appear to be foolhardy.

All dermatologists have experience of malignant tumours which have been frozen, cauterized or disposed of in general practice, so delaying their definitive treatment, sometimes to the point when none is available. The quality of a potentially excellent and immediate service is completely undermined when patients run the gauntlet of such clinical inaccuracies. Any paper discussing the quality of surgery in general practice should highlight this fundamental weakness, rather than try to obscure it. The universal request of a second opinion from the pathologist enhances teaching and quality, and should be viewed as a mandatory component of minor surgery in general practice.

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Sir,

One of the criteria used for assessing the quality of minor surgery in the study by Lowy and colleagues (August *Journal,* p.364) is that of inadequate removal as assessed by a pathologist, which implies that the initial intention was to remove all lesions by excision biopsy. This is not always the most appropriate method of removing lesions. For example, seborrhoeic warts can be easily treated by curettage and diathermy to the base. Benign naevi, particularly on the face, can be treated with shave biopsy with cautery (thus avoiding the scarring that occurs with an excision biopsy). For other lesions a biopsy may simply have been carried out to obtain a diagnosis. These would all be reported by the pathology services as an 'incomplete removal', but nevertheless these procedures may have been more appropriate than formal excision biopsy.

Of the 1447 minor surgical problems treated, 362 were musculoskeletal problems treated by injection. However no attempt seems to have been made to ascertain whether these injections were effective or not. The short waiting time for procedures was noteworthy (about 54% of patients being treated on the day of presentation). This may be because the injections for musculoskeletal problems were all done on presentation, or may imply that full use is not being made or minor surgery lists with nurse support.

The study found that the volume of minor surgery had increased between 1990 and 1991 by 41%. This could, at least in part, be due to the public's increased concern about pigmented lesions rather than the 1990 contract for general practitioners.

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Rural general practice

Sir,

Jim Cox's excellent editorial on rural general practice (September *Journal,* p.388) unfortunately perpetuates the view that suicide rates are higher among men in the rural Scottish highlands than in urban centres. This erroneous assumption is based on a paper by Crombie.[1] Unfortunately, the methodology of this paper and therefore the conclusions are seriously flawed, as detailed in subsequent correspondence.[2,3]

In essence, Crombie's paper took no account of where the suicide victims came from. As a police surgeon working in Inverness-shire I have often been called to remote forest tracks to certify death in people who have driven up from England in order to commit suicide using a hose pipe from the car exhaust. Thus, all these suicides are falsely attributed to the highland population. Later in his paper, Crombie goes on to comment that the

standardized mortality ratios for the Western Isles of Scotland are lower than those for the mainland of the United Kingdom. This gives rather more support to the conclusion that true rural communities with extended families and good social support in fact have lower suicide rates.

Crombie's so called 'epidemiological fact' gives us useful insight into how poor science can be readily assimilated into common belief without question. I have subsequently heard several radio programmes and seen several newspaper articles which assume this epidemiological fact to be correct. This reinforces the importance of the critical reading paper in the MRCGP exam. Indeed Crombie's paper and the subsequent correspondence are used to discuss critical reading with medical students at the University of Glasgow (G Watt, personal communication).

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Fellowship of the RCGP by assessment

Sir,

The Royal College of General Practitioners has launched a new initiative to promote fellowship by assessment, hoping to have 250 new fellows by this route by 1996. The experiences of these pioneers who are prepared to develop their practices and allow scrutiny by their peers should be recorded, for they will be making a major contribution to the development of general practice. Such experiences may not always appear in the official records, however, and would therefore not be available for the benefit of later applicants, or for the history of the profession.

I am keen to gather material on the experiences of those who proceed to assessment and am also interested in the attitudes and opinions of those who have given thought to the principle of fellowship by assessment but who decide not to proceed, perhaps because of difficulties, obstacles or inhibitions. I am also keen to hear from anyone who, for whatever reason, is not in favour of the principle. I hope to publish the results of this research in a book which would be a companion to my book on the MRCGP examination.[1] The project has the approval and support of Professor Mike Pringle, chairman of the RCGP fellowship by assessment working group.

I would be very grateful if anyone who has a view on fellowship by assessment could write to me at the address below. References to such views or experiences in any eventual publication would, of course, be anonymous.

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Reference

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Paperless medical records — approval still awaited

Sir,

Computer systems have been capable of storing general practitioner medical records since the mid-1970s,[1] yet to date this does not have the approval of the Department of Health. The statement of fees and allowances requires that general practitioners keep records on forms provided by the family health services authorities and some authorities persist in trying to enforce this position. To quote from a recent article by the chairman of the primary health care specialist group of the British Computer Society, 'this is clearly anachronistic nonsense' (Royal College of General Practitioners south west Thames faculty newsletter 1994; autumn: 6). Information stored on paper is bulky, time-consuming to file and almost impossible to retrieve and analyse.

For several years interested general practitioners have been under the impression that the National Health Service Executive was working to modernize the rules. However, to date no announcement has been forthcoming. The new rules should state that medical records may be stored on general practice computer systems provided that such systems are confidential to general practitioners and staff, regularly backed up to prevent accidental loss of data, and include an audit trail or other system to show details of any alterations and deletions. Computerized records should be copied or transmitted (either electronically or on paper) when patients change to a different general practitioner so that the new doctor has access to them.

Having dealt with medical records perhaps the NHSE might urgently address the problem of doing away with general practitioner's signatures on electronic claims and prescriptions. It has, after all, been possible for many years to draw cash from a bank autoteller without signing for it.

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Reference

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Non-verbal communication: the lip-reading sign

Sir,

I would like to describe a new sign in general practice. This has come to my notice after using a computer over some five years.

When patients are deaf but unaware that they lip-read, they rely on seeing the doctor's face and lips. During a consultation, the computer screen may be turned to face the patient so that both parties can read it. The result can be a doctor talking to the patient, but facing the computer screen during part of the consultation. If the information is essential and the patient cannot deduce what the doctor is saying, the patient gradually moves position so as to 'lip-read' the doctor. This can become so strong an urge that the patient ends up interposing himself or herself between the doctor and the screen. Perhaps the sign deserves a better name? Any suggestions?

General practitioners who think that patients may be hard of hearing should always ensure that the patient can see the general practitioner's face clearly before the doctor starts to speak, especially if the doctor is about to impart important information.

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