

imum that should be tolerated, and a reliability of 0.95 should be considered the desirable standard.' If it is 'generally accepted' that a generalizability coefficient of 0.8 is sufficient for assessing clinical competence, then one can only suppose that such assessments (and the decisions based on them) are not deemed particularly important.

DAVID BRAUNHOLTZ

Division of General Practice and Public Health Medicine  
Leeds University  
30 Hyde Terrace  
Leeds LS2 9LN

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### Arranging emergency hospital admission

Sir,

In the month when the Secretary of State for Health floated the idea of closing 40% of the National Health Service's remaining acute hospital beds (speech to the National Association of Health Authorities and Trusts, 22 June 1994), the results of a study of problems encountered by general practitioners arranging hospital admission have assumed an even greater importance (June *Journal*, p.251). The study found that problems were experienced by general practitioners during the hospital admissions procedure in 35% of cases, and 21% of telephone calls resulted in a refusal to admit a patient to a particular hospital. The Secretary of State seems to think that the care currently being delivered in these beds can be relocated either to the private sector or to primary care in the community. The balance between these two in the Secretary of State's vision, like much else, is not yet clear.

Those of us who struggle to provide a high standard of primary care against a background of a falling number of hospital beds are fearful about the future. We are told that there are too many hospital beds and yet our regular experience of difficulties in securing a bed for emergency

admission contradicts what we are told. In our bewilderment, it is reassuring to find that our experience is validated by research. Now we must hope that the future planning of the NHS will be based on scientific research rather than political rhetoric.

STEPHEN AMIEL

JUDY BENNETT

IONA HEATH

AZHAR MALIK

DANIEL TOEG

Caversham Group Practice  
Kentish Town Health Centre  
2 Bartholomew Road  
London NW5 2AJ

### Identifying the agenda in the consultation

Sir,

Middleton's interesting paper on the attitudes of general practitioners to lists and the patients who bring them (*July Journal*, p.309) highlights the possible barriers that doctors may have to making full use of patients' written lists in the consultation. He argues that encouraging patients to bring lists might help solve a common communication problem in the consultation, namely that the patient's agenda is not fully identified and addressed.

However, embracing the written lists of those few patients who do bring them is only one way of tackling this fundamental area. The wider issue here is how to help doctors understand the importance of identifying and confirming early on in the consultation as many as possible of the problems that the patient wishes to discuss, whether he or she brings a written list or not. Here, we can learn a lot from North American research and teaching about the medical interview and communication skills which place considerable emphasis on this initial survey or screening of problems and on agenda setting.

Stewart and colleagues have shown that 54% of patients' complaints and 45% of their concerns are not elicited<sup>1</sup> while Starfield and colleagues record that in 50% of visits, the patient and the doctor do not agree on what is the main problem.<sup>2</sup> Burack and Carpenter found that patients and doctors agreed on the chief complaint in only 76% of somatic problems and in only 6% of psychosocial problems.<sup>3</sup> Several investigators have shown that patients often have more than one concern to discuss and the mean number of concerns ranged from 1.2 to 3.9 in

both new and return visits.<sup>2,4-6</sup> These studies warn of the danger of premature and limited hypothesis testing before a wider spectrum of concerns has been identified.

In a key piece of research, Beckman and Frankel have shown that doctors frequently interrupt patients before they have completed their opening statement — after a mean time of only 18 seconds — and that this behaviour both limits the number of complaints elicited and increases the number of complaints arising late in the consultation.<sup>7,8</sup> They have also shown that the order in which patients present their problems does not correlate with their clinical importance. Therefore, the apparent assumption of many doctors that the first complaint mentioned is the chief one may considerably reduce the accuracy and efficiency of the consultation.

Beckman and Frankel have also shown which specific communication skills help doctors to identify as many as possible of the patient's complaints and which skills known to be helpful later on in the consultation, such as clarifying, echoing and repetition, are in fact counterproductive early on in the interview. Several North American teaching texts now propose the following sequence for the early part of the consultation:<sup>9-11</sup>

- encouraging the patient to discuss his/her main concerns by attentive listening without interruption or premature closure;
- confirming the list identified so far by summarizing;
- checking repeatedly for additional concerns, 'is there anything else you wished to discuss today?', until the patient indicates that there is none;
- negotiating an agenda for the consultation.

In the teaching of trainees and trainers in the East Anglian region, explaining that most patients can be expected to bring more than one problem on any one occasion, and that a survey of problems and agenda setting should be part of the structure of all consultations, helps doctors to experience less conflict during consultations, to be more patient-centred and to use time more effectively. Accuracy and efficiency are increased and uncertainty is reduced for both the patient and the doctor. As patients are often unaware of the time allocated to them by the appointment system, and how long it might take to explore any problem with the doctor, early identification of problems allows priorities to be negotiated. Such an open approach at the beginning of the consultation means that the patients are usually agreeable to

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.

JONATHAN SILVERMAN

The Health Centre  
Coles Lane  
Linton  
Cambridge CB1 6JS

JULIE DRAPER

Addenbrooke's Postgraduate Medical Centre  
Clinical School  
Addenbrooke's Hospital  
Hills Road  
Cambridge CB2 2SP

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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.

DAVID DE BERKER

Department of Dermatology  
Royal Victoria Infirmary  
Newcastle upon Tyne NE1 4LP

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.

P W VINCENT

Medical Group Centre  
Durham Road  
Birtley  
Co Durham DH3 2QT

## 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.<sup>1</sup> Unfortunately, the methodology of this paper and therefore the conclusions are seriously flawed, as detailed in subsequent correspondence.<sup>2,3</sup>

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