

Frequency of patients' consulting in general practice

Sir,

Although Dr Neal and his team are to be congratulated on their important article (*January Journal*), I wish to make some additional comment.

While this may be the first inter-practice study of its kind, I quantified the effect of frequent consulting on the clinical workload in a sample population identified for investigating this phenomenon as long ago as 1966.¹ I used this population as the equivalent of a 'laboratory' situation from which I could calculate the effect that the frequent attenders would have on the workload of my practice population. The result was that 16% of the practice population created 43% of the consultations. In those days, before well-woman clinics and other forms of screening, this meant that the effect on the clinical work of the practice had been quantified. The result is not very different from the more detailed description in the Neal chapter on workload, which indicates that I had properly quantified the problem. Their study confirms my claim.

I also argued that the variation in workload, reported in many studies throughout the UK at that time, could be explained by small variations in the proportion of frequent attenders in the population of the reporting practices; although I used different terminology in order to meet the semantic biases prevalent at the time. I think that the Neal team reinforced the validity of this argument in their discussion on modelling the variables. However, it is disappointing that they did not investigate variables other than age, sex, and practice when they considered possible predictors of frequent attendance. Westhead demonstrated in the article from which they quote² that neuroticism and introversion, as measured by the Eysenck Personality Inventory, were relevant characteristics, as was a high GHQ score. This was consistent with my earlier findings.³ I also found that frequent attenders also scored badly on the Raven Progressive Matrices.⁴ Since both Westhead's and my findings have been available for many years, it is puzzling that Neal and his co-workers did not try to build them into their analysis in some way, particularly since one of the team, Morley, is a clinical psychologist.

Dr Neal's team came to the same conclusion as I: that the time and resource implications of frequent attenders are important and need to be addressed. I would suggest that further study of the psychological characteristics that have been demonstrated to be associated with those patients might facilitate the better understanding that the

authors desire. It should be possible to fit these characteristics into a multiple regression analysis and quantify their several contributions. It might even be possible, by establishing how populations vary with respect to them, to build a predictive model for the use of primary care resources calculated from the proportion of frequent attenders identified in this way. Or am I still ahead of my time?

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References

1. Jacob A. An 'artificial practice' as a tool for research into general practice. *J Coll Gen Pract* 1966; **11**: 41-48.
2. Westhead JN. Frequent attenders in general practice: medical, psychological, and social characteristics. *J R Coll Gen Pract* 1985; **35**: 337-340.
3. Jacob A. The personality of the patients in the 'artificial practice'. *J R Coll Gen Pract* 1969; **17**: 299-303.
4. Jacob A. The intelligence of the patients in the 'artificial practice'. *J R Coll Gen Pract* 1968; **16**: 462-468.

Video-recorded consultations

Sir,

In their paper, 'Comparison of video-recorded consultations with those in which patients' consent is withheld', Colman and Manku-Scott (*February Journal*) refer on a number of occasions to the video component of summative assessment. They comment that in summative assessment one would need to demonstrate that behaviour in consultations video-recorded for assessment purposes were not vastly different from others, and then they answer this point by quoting Pringle's work in their article.¹ They are concerned about the content validity of the video. A description of the process would be helpful to the authors. The instructions given to candidates for the video-taped component of summative assessment specify that the tape they submit must demonstrate that they are able to:

- Identify the reasons for the patient's attendance
- Take appropriate steps to investigate the problems presented
- Organize a suitable management plan
- Reach an agreement with the patient on diagnosis and treatment, and
- Demonstrate understanding (in the log) of what was going on in the consultation.

The submitted tape must demonstrate sufficient challenge and give positive evidence of the skills required to pass. It is the responsibility of the GP registrar to choose consultations of an appropriate level of challenge, and this demonstrates insight into the process of competence/performance.

We were invited just over a year ago to demonstrate this tool at the National Board of Medical Examiners in Philadelphia. This body is responsible for all licensing examinations in the United States and its methodology is paper-based. Its members have been trying to develop a consultation model for many years and felt that one of the great strengths of the UK summative assessment methodology was that the candidate chose the material which demonstrated their competence. Although the spread of consultations in relation to everyday general practice is important, it must be looked at in the context of the methodology.

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Reference

1. Pringle M, Stewart-Evans C. Does awareness of being video-recorded affect doctors' consultation behaviour? *Br J Gen Pract* 1990; **40**: 455-458.

How accurately do parents collect urine samples from their children?

Sir,

The paper by Giddens and Robinson (*February Journal*) provides a welcome boost to efforts to diagnose childhood urinary tract infection (UTI).¹ It is perhaps not the 'accuracy' of urine collection by parents that has been improved, but rather the quality of advice from professionals and the provision of equipment to parents. Their method of achieving lower contamination rates on laboratory analysis does, however, seem to have produced a clinically important, if not statistically significant, improvement.

The authors rightly stress that the aim of these efforts is not just to alleviate short-term morbidity, but also to prevent (further) renal scar formation. Therefore, some of the most important data in this paper concern the number of urine samples sent from the children most at risk of renal scarring, i.e. those aged less than two years.² Eight of the 104 samples (7.6%)