

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

References

1. Stewart MA, McWhinney IR, Buck CW. The doctor/patient relationship and its effect upon outcome. *J R Coll Gen Pract* 1979; **29**: 77-82.
2. Starfield B, Wray C, Hess K, et al. The influence of patient-practitioner agreement on outcome of care. *Am J Public Health* 1981; **71**: 127-131.
3. Burack RC, Carpenter RR. The predictive value of the presenting complaint. *J Fam Pract* 1983; **16**: 749-754.
4. Good MJD, Good BJ. Patient requests in primary care clinics. In: Crissman NJ, Maritzla TW (eds). *Clinically applied anthropology*. Boston, MA: D Reidel, 1982.
5. Greenfield S, Kaplan SH, Ware JE. Expanding patient involvement in care. *Ann Intern Med* 1985; **102**: 520-528.
6. Wasserman RC, Inui TS, Barriatua RD, et al. Responsiveness to maternal concern in preventive child health visits. *Dev Beh Ped* 1983; **4**: 171-176.
7. Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. *Ann Intern Med* 1984; **101**: 692-696.
8. Beckman HB, Frankel RM, Darnley J. Soliciting the patients complete agenda: a relationship to the distribution of concerns. *Clin Res* 1985; **33** (suppl): 714A.
9. Riccardi VM, Kurtz SM. *Communication and counselling in health care*. Springfield, IL: Charles C Thomas, 1983: 94-113.
10. Cohen-Cole SA. *The medical interview: the three function approach*. St Louis, MO: Mosby, 1991.
11. Lipkin M. The medical interview and related skills. In: Branch WT (ed). *Office practice of medicine*. 2nd edition. Philadelphia, PA: WB Saunders, 1987.

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.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