terrupted during consultations. The possibility of mistakes arising from verbal messages was also raised.

The system was thought to be particularly helpful following the death of a patient and also where early follow up was important, as in serious illness, essential changes in medication and pressing changes in social support.

Many general practitioners felt the present system was unreliable, with unreasonable delays in receiving discharge letters which at times contained inadequate and inaccurate information. This confirms a study by Harding[3] who found that general practitioners were dissatisfied with the delay in receiving over one third of letters and the content of almost a fifth, and that this adversely affected their management in a quarter of cases. Lockwood and colleagues[5] found that for one fifth of patients no information was available to the general practitioner at the time of the first consultation after hospital discharge, and that a third of these patients suffered poor continuity of care as a result. Penny[4] showed most of the problem lay in delay in the typing of summaries and recommended an increase in secretarial staff.

In order to assess the practicality of the proposed telephone message system in my role of general medical senior house officer, I telephoned discharge information on 100 consecutive cases to the general practitioner's surgery. The time taken and the member of the primary health care team spoken to was recorded. A subjective reaction to the general practitioner's response was noted. Communication time was quick with a mean of 2.4 minutes. It was possible to speak directly to the patient's general practitioner or partner in two thirds of cases, while in the remaining one third, a message was left with the receptionist. In most cases (87%) the general practitioners responded favourably to being contacted in this way and appreciated the opportunity of discussing their patient's further management.

Clearly, there is a need to improve the present system of handover of patient care. As more practices and hospitals become computerized the possibility exists for direct linkage between the two and this could pave the way for future quick transfer of information. However, an opportunity for hospital doctors and general practitioners to discuss the management of their patients allows a greater understanding of respective difficulties and skills and leads to a smoother, more efficient handover of care.

GISELLE SAGAR

12 Anns Place
Stoke
Plymouth PL3 4BJ

References

1. Mageean RJ. Study of 'discharge communications' from hospital. *Br Med J* 1986; 293: 1283-1284.
2. Tullock AJ, Fowler GH, McMullan JJ, Spence J. Hospital discharge reports: content and design. *Br Med J* 1975; 4: 443-446.
3. Harding J. Study of discharge communications from hospital doctors to an inner London general practice. *J R Coll Gen Pract* 1987; 37: 304.
4. Penny TM. Delayed communication between hospital and general practitioners: where does the problem lie? *Br Med J* 1988; 297: 28-29.
5. Lockwood E, McCallum FM. Patients discharged from hospital: an aspect of communication in the health service. *Health Bull (Edinb)* 1970; 28: 75-80.

Action thresholds

Sir,

The paper by Grol and colleagues about attitudes to risk taking among general practitioners from different countries and health care systems takes into consideration how hospital rather than community-based training may lead to a tendency to overdiagnose serious illness (April *Journal*, p.134). Certainly, the making of generalizations on the basis of limited clinical experience, and errors in probability estimation, fall within the realms of 'pathological learning'.[1]

Within British general practice, great variations in doctors' behaviour exist in many areas of professional activity.[2] Wide differences occur where doctors are least confident in their behaviour, for example, when prescribing antibiotics in respiratory illness and tranquillizers in anxiety.[3]

In an attempt to explain this phenomenon, 'thresholds' for activities such as referring[4] and prescribing[5] have been postulated. Individuals may be expected to differ in their reactions to uncertainty: in the area of perceptual judgement, a distinction has been drawn between doctors who prefer the risk of reacting, and possibly being wrong, and doctors who prefer the risk of not reacting and possibly being wrong.[6] In terms of the abstract concept of 'tolerance of uncertainty', not prescribing or not visiting may involve a more active consideration of risk than prescribing or visiting.

'Prescribing thresholds' for antibiotics in acute sore throat were defined for the doctors in two general practices.[5] During a study which assessed the out of hours workload of one of these practices,[7] the data were then analysed to determine the responses of individual doctors in terms of the action of visiting or offering advice on the telephone, and hence a 'visiting threshold' was determined. A comparison was made between individual doctors for both thresholds. A statistically significant correlation between readiness to prescribe and readiness to visit was demonstrated (Figure 1) and, despite the small number of subjects involved in the study we believe that it represents evidence of differences between individuals in their approach to risk taking. The existence of this is consistent with observations that interven-

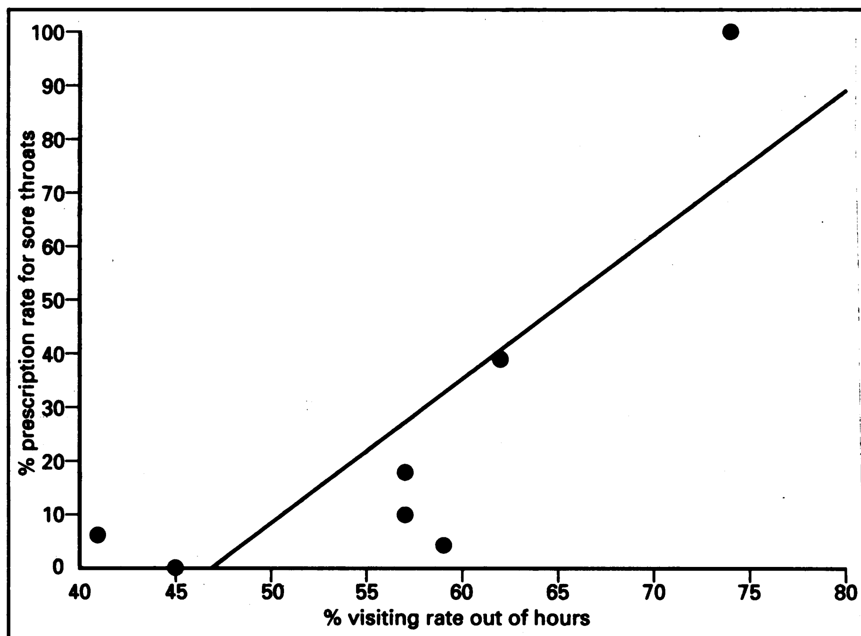

Figure 1. *Correlation between prescription and visiting rates (r=0.82, P<0.05) for seven general practitioners.*

tions such as medical audit have limited or transient effects.

JOHN PITTS
MARGARET WHITBY

Hythe Medical Centre
Hythe, Southampton
Hampshire SO4 5ZB

References

1. Featherstone HJ, Beitman BD, Irby D. Distorted learning from unusual medical anecdotes. *Med Educ* 1984; **18:** 155-158.
2. Royal College of General Practitioners. *Trends in general practice 1979.* London: British Medical Journal, 1979.
3. Freeman GK. 'Do as I say and not as I do'? An audit of clinical management in teaching compared with service work. *Med Educ* 1981; **15:** 110-115.
4. Cummins RO, Jarman B, White PM. Do general practitioners have different referral thresholds? *Br Med J* 1981; **282:** 1037-1040.
5. Pitts J, Vincent SH. What influences doctors' prescribing? Sore throats revisited. *J R Coll Gen Pract* 1989; **39:** 65-66.
6. Bruner JS, Tajfel H. Cognitive risk and environmental change. *J Abnorm Soc Psychol* 1961; **62:** 231-241.
7. Pitts J, Whitby M. Out of hours workload on a suburban general practice: deprivation or expectation? *Br Med J* 1990; **300:** 1113-1115.

Voluntary euthanasia

Sir,
Doctors on the medical ethics committee of the Order of Christian Unity, which represents all mainstream Christian denominations, discussed Dr Bliss's paper on voluntary euthanasia (March *Journal,* p.117) at their meeting in June.

The committee believes that doctors should never consider killing as an option in medicine, no matter how attractive (or cost effective) this may appear as a solution). The first rule of medicine, *primum non nocere* (first do no harm), must continue to be the law under which the profession functions.

Sadly few medical students now understand the importance of the Hippocratic oath, or its updated version in the declaration of Geneva (1948). Is there not a case for reintroducing some form of acceptance of Hippocratic principles after qualification as a doctor?

MARY LANGDON-STOKES

Order of Christian Unity
Christian Unity House
58 Hanover Gardens
London SE11 5TN

What makes patients consult?

Sir,
The question of what influences patients in their decision to consult a doctor is a fascinating one. The paper by Wyke and colleagues (June *Journal,* p.226) confirms that the perceived severity of a symptom is a crucial factor in this decision to consult. I am sure that most general practitioners would agree with this finding. In their study of respiratory illness in children, factors such as the mother's educational level and the number of children in the family under 12 years of age, which had been shown to be important in previous research, did not influence the decision to consult. The authors say that this implies that coughs were worst among the more materially deprived children and that this finding requires further investigation.

Having worked in a deprived area for a number of years, I have noticed that patients from educationally poor and socially deprived backgrounds are sometimes not very good at judging the severity of illness, particularly in their children. The link between social factors and the severity of the symptom does not seem to be in the objective severity of the symptom but in the subjective perception of the severity. Parents of lower socioeconomic status may perceive a cough as worse, and this may explain the findings of the study.

The worrying thing is that the inaccurate perception is not always in the safe direction of perceiving the cough as more severe than it is. I have visited children from deprived backgrounds with 'a bit of a cough' to find a severely ill child who has required immediate admission to hospital. In one recent case the child was lying relatively quietly and not interrupting the social life of the family which probably accounted for the lack of parental anxiety. The parents were terribly upset when they realized how ill their child was, my intervention having altered their perception of the severity of the illness.

By the objective criteria of the medically trained person, patients do consult 'inappropriately'. By their own criteria the decision to consult or not to consult is almost invariably entirely appropriate. Patients' perceptions are different from ours, and in the case of socioeconomically deprived patients, they may be very different. Not necessarily better or worse, but different.

JOHN WINTER

17 Glasven Road
Northwood, Kirkby L33 6UA

Sir,
We were interested to read the paper by Wyke and colleagues (June *Journal,* p.226) which suggested that severity of symptoms and changes in children's behaviour were prime factors influencing parents' decision to consult their general practitioner.

It was not clear whether or not the interviewer was blind to the interviewee's consulting status. This is of crucial importance because, quite apart from identifying potential sources of error on the part of the recorder, careful consideration must be given to the more problematic but well documented effort after meaning[1] which seeks justification for behaviours such as consultation. Similar and equally damaging is prestige bias, whereby people with a strong need for social approval will give answers which they believe will tend to place them in a more favourable or reasonable light.[2] Rather than the perceived severity of symptoms, it seems much more likely that anxiety about the seriousness and meaning of such symptoms influences consultation behaviour.[3] The authors' explanation of inconsistencies in decision making and predicted probabilities actually lends credence to this argument.

An individual's response to any perceived threat, however small, depends on the experience that precedes and surrounds it. Collapsing, in a non-explicit way, the social situation, personal history and prior self-management strategies into a single measure means that there is no way of telling which of the factors that influenced the *z*-scores account for the decision to consult. Social factors were not incorporated into the model but have been shown in numerous studies to affect consultation behaviour.[4] It is therefore possible that demographic variables and perception of symptom severity influence the decision to consult through a third variable which perhaps did not feature in this research. While it seems eminently reasonable to derive a model of behaviour from this information it is quite another to attept validation using the same data. Validity can only be tested prospectively on a different data set and at best, Wyke's 'inexpensive ploy' may indicate reliability but at worse proves neither.

Finally, studies into the decision to consult for specific symptoms do exist;[5] there is, for example, evidence that patients' consultation rates for dyspepsia vary substantially from practitioner to practitioner.[6] The authors conclude from their study that a more fruitful relationship between doctor and patient will result from understanding the process by which the decision was reached. This is obviously true but the patient's agenda is largely made up of their health beliefs and expectations which in turn are influenced by a lifetime's experience. General practitioners struggling with their biopsychosocial triangles and trying to understand what prompted a particular consultation may find it more appropriate and possibly more effective to examine the parents' personal and family concerns over the impor-