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[1] while Starfield and colleagues record that in 50% of visits, the patient and the doctor do not agree on what is the main problem.[2] 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.[3] 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.[2,4-6] 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.[7,8] 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:[9-11]

- 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