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DOI: 10.1136/bmj.332.7552.1226

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colleagues’ study shows that additional problems are identified when patients use an agenda form and when doctors are trained to use such a form. These additional problems come with a price tag, owing to increased consultation time. Little and colleagues also found this. The overall time per problem was unchanged: this was not a case of three problems being managed for the price of two, but three for the price of three. An increase in overall patient satisfaction was seen only in the smaller one of these trials, and it is not known whether the slight delay affected the satisfaction of subsequent patients.

The key issue will be the importance, to the patient or the doctor, of the additional problems or concerns uncovered by the intervention. If these problems were always going to be raised—presumably at a later consultation—then there has been an efficiency gain. This should manifest itself in a reduction in reattendance, though this outcome was not measured. There is a large pool of symptoms in the community which never reach medical attention. Patients judge the seriousness of their problems when choosing whether or not to consult, and they are usually right. Agenda forms may simply medicalise problems that would otherwise not rise above the threshold for consultation. This is not necessarily a bad thing, because the doctor may be able to explain the circumstances in which a similar problem would warrant medical attention.

Perhaps the main benefit from agenda forms is allowing embarrassing problems to be voiced. Until the content of such forms is analysed, however, this must remain supposition and the potential value of agenda forms in routine clinical practice will not have been fully assessed.

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Competing interests: WH and NB have performed a trial of self completed agenda forms in primary care with colleagues, which is yet to report.

The palliative role of orthopaedics

Orthopaedic procedures can help terminally ill patients and are underused

Palliative care for patients with cancer is well established and provides important benefits. Orthopaedic interventions in terminal care are, however, underused in the United Kingdom, despite the fact that conditions that are amenable to orthopaedic intervention occur often in the terminal stages of cancer. Though the evidence base for many orthopaedic palliative interventions is not strong, since there are no trials, clinical experience and expert consensus opinion suggest that such interventions can ease the burden of suffering.