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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 reattendances, 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.


Information and intelligence for healthy populations

In his report on the resources required to provide high quality health services in Britain, Sir Derek Wanless concluded that “little comprehensive information is collected on the health status of the population,” making it impossible to track, at local level, trends in major risk factors and in patterns of disease. England’s Department of Health has now decided that something must be done to tackle this problem and is seeking views on a proposed new strategy for providing such information, Informing healthier choices: information and intelligence for healthy populations.

The government should be congratulated for developing a vision in which real-time, high quality public health data will be delivered via “public health desktops” to a highly trained and integrated public health and local authority work force. It notes correctly that this will be essential for achieving the fully engaged scenario envisaged in Wanless’s first report (about the long term trends affecting the health service in the UK).

The consultation document sets out, in broad terms, how such a vision could be realised. It recognises that creating a fully integrated system will take time and that there is a need to engage with stakeholders, highlighting the central role that will be played by the public health observatories. However, representatives from the much larger number of analysts located in primary care trusts and strategic health authorities are not included in the list of steering group members to implement the strategy, and they need to be.

Major obstacles exist to obtaining consistent, reliable, and accurate data on levels, trends, and patterns of health and healthcare use at local level, some of which the report acknowledges. For example, the census provides denominator data, but up to one million people were missed by the 2001 census. Many of them live in inner cities, and the undercounting combined with high population mobility means that census results from five years ago may be very misleading when applied to current residents in some primary care trusts.

The main source of information on risk factors is the Health Survey for England, typically collecting data on 16 000 adults each year. While the survey’s changing annual focus provides useful in-depth snapshots of different demographic groups and diseases, changes in data collection can make it difficult to assess trends over time. Information on the incidence of many common disorders can be obtained from the Compendium of Clinical and Health Indicators produced by National Centre for Health Outcomes Development (NCHOD), but nearly all these indicators are based on mortality. The General Practice Research Database is another...
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