## Cervical screening

Sir,

Much has been written on opportunistic screening versus case finding and, outside medical circles, doctors are blamed for the continuing, even increasing number of cases of cervical cancer. In our practice we are using a 'belt and braces' approach to cervical screening.

Our invitation for a well woman check offers a smear test, blood pressure measurement and breast examination. When the letter goes out, a stamp goes in the notes to remind the doctor to check that the smear has been carried out at the next patient contact. The second letter also carries a stamp, and seems to make quite a few women attend, particularly as it states that there will be no more reminders.

Twice a year the practice manager sifts through the notes of the non-attenders and stamps them with an eye catching red stamp which is intended to encourage the doctor to discuss cytology at the next contact. The practice manager brings to my attention any non-attenders she feels worried about, for example, those with a history of inflammatory smears.

Thus, we are using both case finding and opportunistic methods to screen all the patients who are willing to attend.

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## Child abuse — the Cleveland disaster

Sir,

Among the many lessons to be learnt from the Cleveland disaster is the application of quite simple methods of clinical reasoning.

The fundamental considerations are these:

1. There is no judgement without error.
2. Any single test or procedure has a characteristic false positive and false negative rate.
3. A test which is valuable in a high prevalence situation (where abuse is suspected for other reasons) is useless in low prevalence situations (among hospital admissions for other reasons).
4. A hypothesis, for example that abuse has occurred, may only be held if it resists attempts at falsification as well as being consistent with supportive evidence, and then it may only be held provisionally.

It may be that the burden of having to make these dreadful decisions could be eased to some extent by bearing these considerations in mind.

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## Prescribing requirements of the elderly mentally handicapped

Sir,

I read with interest the paper by Dr Walters (July *Journal*, p. 317) concerning the prescribing implications of the deinstitutionalization of elderly residents of hospitals for the mentally handicapped. However, the severity of the handicap of the patients under Dr Walter's care is not entirely clear: the implication appears to be that the elderly mentally handicapped are seriously impaired. Several recent studies, while confirming the high prescribing needs of this group, suggest that they may not be very handicapped intellectually. For example, actuarial studies by Wold and Wright[1] have shown that after the period of infancy, life expectancy is related to the degree of handicap, leading to the differential survival into older age of less impaired individuals. Day,[2] in studying the total elderly population of Northgate Hospital, Northumberland, discovered that two-thirds of those aged over 65 years, had mild or moderate degrees of handicap. Krauss and Seltzer[3] showed that the elderly mentally handicapped in hospital and the community were less impaired than those who were younger. A similar finding was made by Linter.[4]

Despite the relative intellectual fitness of the elderly mentally handicapped, it is questionable how far the present policies of deinstitutionalization should apply to them. In Dr Walter's hospital, two-thirds of the elderly have been inpatients for over 50 years. They will almost certainly have made longstanding relationships with other residents and staff. Their ability to make informed choices as to where and how they wish to live the remainder of their lives remains unclear. James[5] suggests that they may respond poorly to the inevitable breakdown of established social networks, and may be rendered liable to psychiatric disorders in consequence. As Day[2] points out, it is essential that the capacity of the elderly mentally handicapped to adjust to and benefit from radical changes in the pattern of their lives is fully evaluated before they are automatically included in large-scale deinstitutionalization and resettlement programmes.

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**References**

1. Wolf LC, Wright RE. Changes in life-expectancy of mentally retarded persons in Canadian institutions: a 12-year comparison. *J Ment Defic Res* 1987; **31**: 41-59.
2. Day KA. The elderly mentally handicapped: a clinical study. *J Ment Defic Res* 1987; **31**: 131-146.
3. Krauss MW, Seltzer MM. Comparison of elderly and adult mentally retarded persons in community and institutional settings. *Am J Ment Defic* 1986; **91**: 237-243.
4. Linter C. Aspects of ageing in mental handicap. *Br J Ment Subnorm* 1986; **32**: 114-118.
5. James DH. Psychiatric and behavioural disorders amongst older severely mentally handicapped patients. *J Ment Defic Res* 1986; **30**: 341-345.

## Recognition of emotional disturbance in the consultation

Sir,

We would like to comment on the recent paper by Whewell and colleagues (June *Journal*, p.259). The authors assert that there is only one study comparable with theirs,[1] but during the past year, while their paper has been in press, two comparable studies of the results of teaching interview skills to general practitioners by video feedback have been published — one involving established doctors,[2] the other trainees.[3] Both used the 'problem-based interview' model outlined by Lesser[4,5] and showed that such teaching successfully increased the accuracy of recognition of emotional disturbance by trainees and altered interview behaviours by both trainees and established general practitioners.

Unfortunately Whewell and colleagues do not outline any model or structure in their teaching procedure. The use of a model of the consultation process for teaching consultation skills has several advantages: it gives a structure with which participants can judge, understand and revise their performance, and it allows repetition of the teaching scheme in different places with, and by, other individuals. This last point is of great importance, and following the success of the previous studies we have recently set up a collaborative project between our centres in London and Manchester. This differs from the past studies in that it uses general practitioner trainers and involves not only teaching them the skills of communication but also giving them guidelines on how to teach these skills effectively to their trainees using video or audio-taped material. So far, the study has met with great enthusiasm among trainers in the south east and north west regions.

Such a means of teaching communication skills has many advantages. It avoids the problem of diagnosis as it focuses on the many problems that patients bring to the consultation and in this way is adap-