perience of examiners for the Diploma in Geriatric Medicine. However, it is surprising that geriatricians did not know of its existence, for though it is not in universal use it is almost certainly the best known means available of measuring disability. The Barthel index is a scoring instrument most helpful for people with severe disability. Any doctor with a particular interest in disabled or elderly people is likely to find it useful.

A TULLOCH

36 Church Lane
Wendlebury
Bicester
Oxfordshire OX6 8PN

References

1. Row OC, Bieren K, Bjornsen LE, *et al. Eldreomoskorgens nye giv-et. Eksperiment med styrket innstats in primaertjenesten i Oslo. Rapport nr. 6.* Oslo: Gruppe for Helsejenesteforskning, 1983.
2. Hendriksen C, Lund E, Stromgard E. Consequences of assessment and intervention among elderly people: a three year randomized controlled trial. *BMJ* 1979; **289:** 1522-1524.
3. Rubenstein LZ, Josephson KR, Wieland GD, *et al.* Effectiveness of a geriatric evaluation unit. A randomized controlled trial. *N Engl J Med* 1984; **310:** 1664-1670.
4. Tulloch AJ, Moore V. A randomized controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **29:** 733-742.
5. Carpenter GI, Demopoulas GR. Screening the elderly in the community: controlled trial of dependency surveillance using a questionnaire administered by volunteers. *BMJ* 1990; **300:** 1253-1256.
6. Kane RL, Evans JG, McFadyen D (eds). *Improving the health of older people: a world view.* World Health Organization and Oxford University Press, 1990.
7. Wade DT, Collin C. The Barthel ADL index: a standard measure of physical disability? *Int Disabil Stud* 1988; **10:** 64-67.

Sir,

Dr Tulloch argues in his editorial that we must be better trained in preventive care of elderly people (September *Journal*, p.354). He assumes that many problems are preventable, that there are resources to deal with what is detected, and that there is time to deal with both the workload of current disease and to provide preventive care. However, the current lack of orthopaedic, ophthalmic and cardiac care for elderly people is a major problem. My elderly patients routinely spend several months on 180 mg or more of codeine phosphate daily before they can have joint surgery.

In my area, screening for patients over 75 years of age was welcomed by the community nursing service. They drew up a protocol in conjunction with the local geriatrician, which more than satisfied the new contract regulations. Assisted by general practitioners and practice nurses they screened all elderly patients but in my practice very few new problems were discovered. We general practitioners did not (pre-new contract) and do not now engage in screening; we rely on an informal network of home helps and other carers to tell us of problems.

Examples of problems among elderly patients over the last two months include a woman with arteriopathy who refuses treatment; an obese depressive patient with an inflammatory arthropathy — recently admitted to a rheumatology unit; and an independent bachelor who refused to leave his house, where he was not coping, until he developed double incontinence.

All three cases and many others needed a lot of time and effort and none of them could be described as preventable in any realistic sense. All of these patients had been comprehensively screened within the last year and none of their problems had been uncovered.

I suggest that the situation is much more complicated than Dr Tulloch suggests; the ultimate determinant of care for elderly people is the value placed on elderly people by their community. In my area elderly patients are well looked after because they are valued and respected in the community; things can be different and no amount of preventive care will compensate an elderly person for the knowledge that they are in the way.

DECLAN FOX

Little Pubble
2A Bunderg Road
Newtownstewart
County Tyrone BT78 4NQ

Confiding relationships in elderly people

Sir,

The paper by Dr Iliffe and colleagues (November *Journal*, p.459) is depressing in its conclusion that confiding relationships in elderly people are not worth enquiring about routinely because they do not appear to confer protection against depression. This would appear to justify current practice. It has been my experience over many years of preparing summaries from patients' notes that the vast majority of notes contain little information on family structure. The call for the family gram[1] seems to have fallen on deaf ears. Yet most psychiatrists, and all psychoanalysts, realize that you cannot know anybody well without having an intimate knowledge of their childhood and their relationships. How can we, as general practitioners, arrive at the opposite conclusion about taking a history, and the importance of our database?

I feel that Dr Iliffe and colleagues' conclusion needs more consideration. Perhaps the methodology of such research should be re-examined. Were the standards of judging depression which were used accurate? Was the questioning of patients aged 75 years and over by 'trained non-medical field workers' adequate? And what of the definition of confiding relationships? The question asked by Iliffe and colleagues contained four scenarios, and two different criteria by which to judge who to turn to — who would you talk to about private matters, who when you are in a crisis, who when you are worried, who when you are stressed, who can you count on and who are you at ease with? I might go to the bank manager in a crisis, to the doctor when worried, not be able to talk to anyone about private matters, go to the public house when stressed, know that I can rely on my neighbour to feed the cat if I am away but only feel at ease with my long deceased mother. The permutations may be endless.

Human relationships are complex but deeply interesting and exploration of them has given me an understanding of why a patient is ill on many occasions. The conclusion reached by Iliffe and colleagues is simplistic and unconvincing.

TONY WALSH

Walnut Tree Health Centre
24 Dunchurch Dale
Walnut Tree
Milton Keynes MK7 7BS

Reference

1. Hodgkin K. *Towards earlier diagnosis.* Edinburgh: Churchill Livingstone, 1985: 728.

Opportunistic screening

Sir,

Dr Baker's letter (September *Journal* p.390) about the need for an agreed terminology for 'opportunistic screening' is a useful addition to the debate. To clarify matters, in our paper[1] we were attempting to address the factors which may influence the coverage achieved through general practitioners opportunistically offering invitations to individual patients to attend a well person consultation organized on an appointment basis. Thus, the key point of our paper is that the method of organizing screening programmes has an important effect on their effectiveness.

This point seems to have been missed by Baker who concludes 'Not only is screening possible on an opportunistic, individual basis, but in fact, with properly developed software, it is possible to "screen" the whole of the practice population in quite a short space of time if the software is organized so that the whole