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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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-

table to all consultations and not just those of a 'psychiatric' nature. In addition, it avoids the jargon on psychotherapy which often alienates doctors and instead focuses on the behaviour of doctor and patient.

Evaluation is essential for any innovative project and Whewell and colleagues used changes in accuracy (as measured by kappa) to measure the effectiveness of their training course. The use of accuracy measures would be of more value if these could be linked to changes in consultation behaviour, especially if this behaviour were then targeted in the training course. While it is legitimate to use kappa as an index of accuracy it raises a problem mentioned by the authors, that of defining a 'case'. Two previous studies[6,7] have used Spearman's rho as the measure of accuracy, a method which avoids having to define a case. Comparison of the results of these two studies suggests that while there may be major differences in the prevalence of emotional disturbance in the two centres, the overall accuracy of the general practitioners is very similar. The importance of this is that accuracy is strongly predicted by the interview behaviour of the doctor[6,8] and as such is amenable to change.

Of interest is the way in which accuracy changes after training. The results of Whewell and colleagues are almost identical to those of Gask and colleagues[3] — accuracy increased in the majority of general practitioners but falls in the doctor with the highest score before training. The power of the teaching method used may unsettle the previously skilful interviewer and reduce his or her performance, presumably temporarily. This is an important reminder of the usefulness of video feedback in teaching communication skills which, if used well, can be a powerful and rewarding tool.

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Using the census to define needs

Sir,

In their papers on census data (October 1987 *Journal*, p.448 and 451), Hutchinson and colleagues drew attention to this rich source of sociodemographic data for small areas and described how it might be used to define the degree of deprivation of a practice population in order to make a case, for example, for extra staff. We would like to draw attention to other applications of linking census data with primary care data, both in evaluating new methods of health care in general practice and in targeting health care where it is most needed.

Research in general practice is bedevilled by difficulties in interpreting the difference that exists between practices in relation to almost every measure of process and outcome of medical care. Rarely are we able to relate how much of this difference is due to the health and social circumstances of the patient population and how much is related to the medical care offered. Linking the socioeconomic data from the census to individual general practice populations provides a method for standardizing to some extent the patient populations under study. Such data may be of considerable use in setting up randomized controlled trials of new methods of health care delivery which need to use whole general practices as a unit of randomization.

In order to target health care more effectively, we have recently drawn up maps of our practice area of 2.8 square miles, on the basis of enumeration districts, to display the areas in the top 10% for Southampton for unemployment, single parents, overcrowding, large families and occupational classes 4 and 5. We have found that these areas tend to reflect the areas of risk for health problems such as childhood accidents, so that rational preventive programmes could be centred on single high risk streets.

In the course of this work, however, we found that only 557 of the 2250 children under five years old living in the practice area were actually registered on our list and that 72 general practitioners from 18 practices were involved in the care of the others. Clearly, if we are to take advantage of this method of determining needs, individual practices will need to group together into neighbourhood prevention groups in order to develop effective strategies for treatment.

In our view systematic knowledge of pathology in relation to local geography could become as useful a part of the general practitioner's stock-in-trade for preventive work as knowledge of individual family pathology is now for treatment. We therefore hope that the 1991 census will be designed to make this linkage as easy as possible. This would include improving the geographical precision of postal codes and the provision of small area statistics for areas defined by postcodes.

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Intimacy and terminal care

Sir,

I was interested in the letters by Dr Carnwath and Dr Wilkinson (June *Journal*, p.276) in response to my article (March *Journal*, p.121). Dr Carnwath provided an historical perspective, for which I thank him, and I would also like to thank the many colleagues who wrote directly. Many cited instances from their own working experiences of the quality of a pre-existing sexual relationship having repercussions for patients giving and accepting intimacy in the terminal care setting.

Dr Wilkinson correctly states that many complex and intertwined factors determine where a patient dies — the physical nature of the dying as well as the psychological factors. My paper, however, was attempting to concentrate on the neglected area of intimacy and terminal care. Dr Wilkinson argues that 'Mr B.'s screams were not necessarily for a wife who could brush his hair but perhaps for anyone who loved him enough to brush his hair'. She is perfectly correct; that was the interpretation I made and was the impetus to have him admitted to a hospice, where he might find some 'tender, loving care'. His wishes were indeed the cue for action. After her bereavement, Mrs. B. spoke more openly about the coldness in