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.

A.P. BOARDMAN

National Unit for Psychiatric Research Development
Lewisham Hospital
Lewisham High Street
London SE13 6LH

L. GASK

Department of Psychiatry
University Hospital of South Manchester
West Didsbury
Manchester M20 8LR

References

1. Goldberg D, Steele J, Smith C, Spivey L. Training doctors to recognise psychiatric illness with increased accuracy. *Lancet* 1980; 2:521-523.
2. Gask L, McGrath G, Goldberg D, Miller T. Improving the psychiatric skills of established general practitioners. Evaluation of group teaching. *Med Educ* 1987; **21**: 362-368.
3. Gask L, Goldberg D, Lesser AL, Miller T. Improving the psychiatric skills of the general practitioner trainee. An evaluation of a group training course. *Med Educ* 1988; **22**: 132-138.
4. Lesser AL. The psychiatrist and family medicine: a different training approach. *Med Educ* 1981; **15**: 398-406.
5. Lesser AL. Problem-based interviewing in general practice: a different training approach. *Med Educ* 1985; **19**: 299-304.
6. Marks J, Goldberg D, Hillier V. Determinants of the ability of general practitioners to detect psychiatric illness. *Psychol Med* 1979; **9**: 337-353.
7. Boardman AP. The general health questionnaire and the detection of emotional disorder by general practitioners. A replicated study. *Br J Psychiatry* 1987; **151**: 373-381.
8. Goldberg D, Steele JJ, Johnson A, Smith C. Ability of primary care physicians to make accurate ratings of psychiatric symptoms. *Arch Gen Psychiatry* 1982; **39**: 829-833.

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.

ANN-LOUISE KINMONTH
RACHEL BURCH

Primary Medical Care
Aldermoor Health Centre
Aldermoor Close
Southampton SO1 6ST

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