there are very few cases to which the question: 'Has the patient benefited from medical intervention?' cannot be met with an answer of 'Yes' or 'No'. A negative answer should not be seen as a disgrace so much as an education; the mistake is not to ask the question.

A single prefix may be the answer: 'Beneficial patient care'. Were this new term to be used with the same frequency as the old, it would not of course have the same public relations appeal — it implies alternatives. However, it is likely to make true quality assessment, each time a doctor treats a patient, habitual; and so prompt, if necessary, beneficial adjustments to future practice.

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Breast self examination

Sir,
David Mant (May *Journal*, p.180) correctly summarizes the consensus of the literature on breast self examination in asserting that there is no evidence that it is effective in reducing mortality from breast cancer. However, there is equally no evidence that it is not effective. Quite simply it has never been practised on the scale and with the reliability necessary to settle the matter. This is because even those women who respond favourably to the offer of appropriate instruction require intensive guidance, supervision and continued reassurance if they are to remain both motivated and confident in their ability to distinguish the normal from the abnormal.[1-3]

However, as Dr Mant says, women are likely to examine their breasts whether or not they are taught breast self examination. There would be much to be said for ensuring that such examination is done so as to achieve an optimal balance of sensitivity and specificity and to limit the anxiety which may be the main outcome of ineffective practice. This is unlikely to be achieved by posters and pamphlets but it might well be achieved in general practices able and willing to invest the necessary resources. Although it may remain formidably difficult to subject the efficacy of breast self examination to formal appraisal, there must surely be some benefit from ensuring that what will inevitably be done is done more effectively.

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Sir,
Dr Mant's editorial (May *Journal*, p.180) seeks to promote critical debate and appraisal of the role of breast self examination in the prevention of breast cancer. There are two complementary, but distinct, issues here: the validity of breast self examination as a screening test, and the importance of the early diagnosis of breast cancer in reducing morbidity and mortality. Whereas the value of breast self examination as a screening test may be in doubt, the importance of early diagnosis of breast cancer is not.

Lundgren points out the differing response of Swedish and British women to the discovery of a palpable breast lesion.[1] Swedish women present with less advanced breast cancer than their British counterparts, which is reflected in a superior mortality to incidence ratio in Swedish women compared with British women (36% and 60% respectively). Furthermore, it must be remembered that much of the morbidity and mortality from breast cancer occurs outside the 50–64 years age group which is targeted for mammography. In the St Helens and Knowsley district in 1987, there were 86 deaths from breast cancer, of which at least 55 (64%) were among women who would not have been within the target population for mammography.

To discourage breast self examination because of its questionable validity as a screening test may well discourage women from presenting early with palpable breast lesions, and lead to an increase in morbidity and mortality. A crucial health promotion role exists for general practitioners in encouraging properly conducted breast self examination and with it increasing the awareness of the potential benefits of early diagnosis of breast cancer. It may yet be shown that at a particular age or in other specific groups, breast self examination is an effective screening procedure, most likely in women over 40 years of age.

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Screening and the new contract

Sir,
The government's proposed new contract states that we are now to screen everyone from the age of 16 years every three years until the age of 74 years, and annually (by home visit) thereafter. This raises the ethical question of whether as responsible general practitioners we should be involved in this activity.

First, as far as I am aware there is no evidence that triennial screening of the young is of any value. Furthermore, actively encouraging the fit young to attend may 'medicalize' health and a paper by Dr Stoate (May *Journal*, p.193) suggests that screening may actually cause psychological harm to healthy volunteers.

Secondly, while there is some evidence that annual screening of over 75 year olds may be of value, there is no comparative evidence to state that one method is better than another (for example, letter followed by a visit if indicated versus selective visits of those not seen in the previous year). One could also postulate that social services screening of the elderly would be of more value than medical screening, since social support is what the elderly usually need. I am not aware of a comparative study being done. Visits to those elderly who already attend surgery will encourage dependence on visiting by the general practitioner.

Finally, the kind of screening proposed has not been shown to fulfil the criteria for screening mentioned by Stoate.

As a doctor I should not be actively involved in something that could damage peoples' health. The contract stipulates that I must. Is there an answer to this dilemma?

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Screening: the case against

Sir,
When I first read the title of Dr Stoate's paper, 'Can health screening damage your health?' (May *Journal*, p.193), I assumed