in the general field who have been struggling with their care. While the short term effect is beneficial to patients and their families, the longer term effects of such intervention may provide for alternative rather than complementary resources.

It is possible that the development of palliative medicine as a distinct specialty may add to this isolation, when it may be most effective in drawing together those involved, sharing skills and strengthening the roles of those in primary care.

The nursing profession has benefited greatly from the appointment of Macmillan nurses. These nurses must have had community training and not only do they readily understand the problems of district nurse colleagues, they will also have developed an understanding of the changes in family dynamics that follow a serious illness in the home. The major components of the clinical nurse specialist role are advanced clinical practice, teaching, management and research. These are closely mirrored by the activities of the physician in palliative medicine. Doctors training in palliative medicine should have experience in general practice.[2] Acceptance of such experience as mandatory may encourage the development of physicians in palliative medicine who understand and support the general practitioner's primary role, and who work towards the management of terminal illness within the primary health care team.

Palliative medicine has come a long way since 1967. Paradoxically, in order to develop effectively in the future it must be seen as a specialism that requires skills that can be acquired by all. The general practitioner and the district nurse must remain as the prime workers and any further growth in hospice care should be towards supporting those who already deliver that care. The appointment of physicians in palliative medicine could be a major step in providing this support.

The Association for Palliative Medicine has considered the problems of teaching and training in palliative medicine and is continuing to develop plans for the future. The development of the post of physician in palliative medicine should be guided by aims similar to some of those outlined by the Association for Palliative Medicine. He or she should awaken and cultivate interest in palliative medicine and be proactive in the education of other health professionals. He or she should be aware of, and investigate further, not only physical and psychological but also social and spiritual aspects of disease and should further the understanding of these aspects by appropriate research.

The development of a new medical role in palliative care may be seen not as a replacement for that of the hospice medical director, which may be appropriate in many situations, but as an alternative where the needs of the community and of existing services demand. The preparation for this role must, however, be necessarily different from that needed for the traditional role, demanding the skills of community care alongside an awareness of the special needs of dying patients and their relatives, together with an interest and understanding of educational requirements.

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References

1. Wilkes E. *Terminal care report of a national cancer sub-committee working group.* London: DHSS, 1980.
2. Finlay I. Training for hospice care. *J R Coll Gen Pract* 1989; **39:** 1-2.

Double standards for screening

Sir,

Double standards are being applied to screening elderly people and surveillance of children under the age of five years, as experienced colleagues have pointed out in the debate on paediatric assessment.[1] Child health surveillance yields relatively few problems that need or are amenable to medical management, is done well by health visitors and better by parents, yet has been the subject of prolonged campaigning by general practitioners[2] and is now firmly embedded in the new contract for general practitioners.

Assessment of elderly people, on the other hand, is likely to find that one in five of those aged 75 years and over have some degree of depression, with 3% or so having severe depression with a poor prognosis unless adequately treated.[3] Between 6% and 12% of the elderly will show some degree of dementia,[4] and a large minority of their carers will demonstrate significant stress and strain.[5] These two groups of elderly patients overlap only slightly, so that up to 30% will have psychiatric morbidity to some degree.

General practitioners underdiagnose dementia[6] and undertreat depression[7] in elderly people, yet training in assessment techniques is not part of the requirements of the new contract and evaluated screening instruments have not been proposed for use by other health workers. Worse still is the temptation for overworked family practitioner committees to offer their general practitioners checklists for assessment of elderly patients in which inadequate descriptions of pathological mental states — aggression, confusion, withdrawal — are buried among questions relevant to community surveys of need but inappropriate for case-finding and problem-solving in general practice.

To ease workload elderly patients who have been seen in the course of the year by district nurses, a health visitor or their general practitioner may well be counted as already 'assessed', so that information of dubious value may be collected on those not seen, who may turn out to be healthy members of the biological elite. Significant but relatively small changes in cognitive function heralding dementia and impending decline in functional ability may be overlooked in medical consultations about other problems, or by nurses concentrating on immediate tasks, while the somatic preoccupations of the elderly depressive are overshadowed by their all-to-real physical problems.

Checklists focus attention and are better than neglect, but training in the use of screening instruments and in diagnostic techniques remains a necessity that the new contract ignores. Is this the way to overcome medical nihilism towards psychiatric illness in the elderly, or to support the carers upon whom 'care in the community' really depends?

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References

1. Thompson MK. Child health surveillance. *Br Med J* 1990; **300:** 536.
2. Butler J. *Child health surveillance in primary care: a critical review.* London: HMSO, 1989.
3. Baldwin RC, Jolley DJ. The prognosis of depression in old age. *Br J Psychiatry* 1986; **149:** 574-583.
4. Henderson AS, Kay DWK. The epidemiology of the mental disorders in the aged. In: Kay DWK, Burrows GD (eds). *Handbook of studies in psychiatry and old age.* Amsterdam: Elsevier, 1984.
5. Levin E, Sinclair I, Gorbach P. *Families, services and confusion in old age.* Hampshire: Avebury, 1989.
6. O'Connor DW, Pollitt PA, Hyde JB, *et al.* Do general practitioners miss dementia in elderly patients? *Br Med J* 1988; **297:** 1107-1110.
7. Macdonald AJD. Do general practitioners 'miss' depression in elderly patients? *Br Med J* 1986; **292:** 1365-1367.

Screening elderly people

Sir,

In their timely paper on screening elderly people in primary care (March *Journal,* p.94) McEwan and colleagues observed 16 deaths among 151 patients in the test group and 23 deaths among 146 in the