depressive symptoms in chronic fatigue syndrome. The anecdotal reports of side effects of antidepressant drugs used in chronic fatigue syndrome patients are insufficient evidence to damn a potentially useful treatment for depressive symptoms, bearing in mind the risks of leaving a concurrent reactive depression untreated, and of suicide risk in what is acknowledged to be a chronic condition. We are not aware of any case where antidepressant drugs have caused a permanent adverse outcome regarding chronic fatigue syndrome. Response and how well the treatment is tolerated depend on many factors, but with careful assessment and selection,[1] chronic fatigue syndrome patients with concurrent depression of moderate severity usually benefit from treatment with the newer, less sedative antidepressant drugs.

Regarding spontaneous recovery, the patients treated in our studies had concurrent major depression, and in over 50% this was present for several months before treatment. Twenty five patients with similar symptoms and characteristics who refused antidepressant treatment (and were offered cognitive therapy) tended to have a longer duration of depressive symptoms which were more severe than the group treated with antidepressant drugs. These findings would tend to argue against spontaneous recovery but of course it cannot be excluded.

Several centres in the United Kingdom are now undertaking controlled trials of antidepressant drugs in chronic fatigue syndrome and until the results are known clinicians may need to try treatments for chronic fatigue syndrome on an open basis (including antidepressant drugs) to alleviate suffering.

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Patient satisfaction and style of practice

Sir,

Dr Johnson's letter (September *Journal,* p.386) should lead us all to reflect on patient satisfaction. Measurement of patient satisfaction is not a new concept in general practice but can it influence doctor behaviour?

In 1984 I was a trainee in a practice in the south west of England. The practice had a reputation for quality, fulfilling all the objective measures of quality as promoted by the Royal College of General Practitioners in terms of records system, practice management and medical protocols. All the partners were RCGP members. I attempted to measure patient satisfaction by questionnaire, using selected criteria from the RCGP working party report 'What sort of doctor?'.[1]

All 572 patients over 18 years of age attending the practice in a one week period were asked to complete a questionnaire. A total of 189 replies were received (33% response rate). The replies revealed that 99% of respondents knew with whom they were registered and that 79% felt that they 'had a special relationship with their own doctor'. Of the respondents 95% felt that the doctor should encourage them to look after their own health and 87% felt that their doctor did this. Only 4% of respondents thought there was a remote possibility that the doctor might pass on any confidential information. Sixty seven per cent of respondents felt that they could have an appointment to see the doctor at the surgery, and 80% a home visit, at any time.

With hindsight I can see many faults with my survey but it was the general message that most influenced me. The patients seemed more than satisfied and many volunteered words of praise on their questionnaires. This project marked a turning point in my general practice aspirations. This practice was to be the benchmark for my future career. I wonder if, seven years on, I would have the courage to repeat the study in my own practice?

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Reflotron measurement of blood cholesterol

Sir,

I read with interest the letter by Curzio and colleagues (October *Journal,* p.433). The results they obtained in their comparison of Reflotron® (Boehringer) and laboratory measurements of blood cholesterol were disappointing.

Previous studies have generally achieved correlation coefficients of approximately 0.95, and a mean difference and standard deviation of less than 0.5 $mmol^{-1}$.[1-3] Operator training is known to have a major impact on accuracy of Reflotron measurements.[4] The poor Reflotron performance may have been due to inadequate training of the operators and/or a poor system of quality control. Additionally, no mention was made of how the accuracy of the laboratory measurements was determined. It is therefore difficult to determine what proportion of the poor Reflotron performance was in fact attributable to laboratory error.

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Reaccreditation of GPs

Sir,

Accreditation and reaccreditation of general practitioners are topical issues. It is my hope that these issues will be linked to fundamental changes in postgraduate education, making the content of hospital posts in the vocational training scheme more sensitive to the needs of future general practitioners, and permitting educational assessment of general practitioners as individuals and within the context of the primary health care team.

To achieve this, the core of a training scheme should perhaps include training in psychiatry and geriatric medicine, the

content of each post being based on nationally agreed topics, possibly from a modification of the Wolverhampton grid which has been in use in the West Midlands region for over 20 years (Wall D, regional adviser, personal communication). The role of the general practitioner in intrapartum care in the United Kingdom requires open discussion, as current training requirements for the obstetric service fail to meet the needs of general practitioners.

Should accreditation involve satisfactory completion of continuous assessment during the hospital-based years for each specialty, or is an end of course examination preferable? Would the examination be the MRCGP, or a less demanding one, but of similar style? The incorporation of continuous assessment into accreditation may promote learning and help identify teaching deficiencies within a specialty.

Regarding the year spent as a trainee in general practice, an agreed content of half day release courses, and the setting of national standards of assessment of trainers and trainees may be steps forward.

Reaccreditation every three or five years, could include distance learning modules each of six months' duration, separate from but covering the same broad headings as the postgraduate education allowance approved courses. The modules could be designed to assess individual learning and promote group study within practices, the latter involving clinical and managerial issues, including audit exercises. Failure to complete a module successfully would lead to directed study and reassessment. Those not meeting reassessment criteria could have their individual learning needs assessed by representatives of the Royal College of General Practitioners, with a further period of directed study. Withdrawal of accreditation would occur if a doctor's performance at reassessment is unsatisfactory. Discussion must follow to identify how such doctors can be helped to achieve the prerequisite educational standards for reaccreditation.

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Audit in general practice

Sir,

I have recently attended the Scottish National Audit Conference, and the organizers are to be congratulated for such an excellent programme. Personally, I felt greatest empathy with the speaker who argued against audit.

Audit is only one of many methods of assessment, and it should be considered carefully. Time spent on audit may distract from our primary task of seeing patients and sometimes even from addressing the problem it investigates. Senior partners can use audit in the same way as a committee chairman forms a subcommittee to avoid action.

It was regularly asserted at the conference that if we failed to carry out audit then it would be imposed; however, it already is with, for example, prescription pricing. This asks what is being spent on drugs, the data is accurately collected by an independent and adequately funded service, and change is encouraged through appropriate interpretation of the results. Practice reports are another example of audit. However, it is uncertain which question they are addressing and their data are grossly unreliable — no one at the conference could guarantee their own data accuracy, far less a lack of observer bias.

The second example demonstrates the real problem: a question must be clearly defined, and data must be accurate. In order to be of value it must be accurately collected, and displayed in an understandable form. Only then can conclusions be drawn, and change implemented. It is a lengthy and arduous process; it should not be allowed to replace highly effective and efficient common sense.

As providers of a service, we should regard audit as no more than an interesting, and sometimes useful tool. If we allow it to eclipse common sense and experience, then we all lose. If others choose to impose it, then we must ensure that they draw the right conclusions from their data. Time spent with patients should not be taken away to provide audit data of dubious value, as happens now and is threatened for the future.

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Surgical simulation for general practitioners

Sir,

An article by Capperauld and Hargraves in the *Annals of the Royal College of Surgeons* is an interesting and timely paper.[1]

Simulation in training and the assessment of competence using simulators has been commonplace in some professions for a long time, for example in the training of airline pilots. Simulation in surgical training has been in existence for over a decade. Capperauld and Hargraves describe the use of freeze dried porcine skin which is immersed in water prior to use. It is claimed to have the texture of normal human skin. The use of a subcutaneous vitamin C capsule and polyethylene tubing to resemble a sebaceous cyst and a subcutaneous vein is simply ingenious.

Manual dexterity, safe handling of instruments and respect for human tissues are essential for the successful conduct of any surgery and a reduction in the number of complications. This article should make interesting reading for all general practitioners involved in minor surgery and for those responsible for the training of colleagues.

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Appliance for hemiplegic patients

Sir,

We would like to bring to the attention of readers a simple way of helping hemiplegic patients with walking.

We have found that 2 yards of 1.25 inch elastic, together with two safety pins and a keyring is all that is necessary. The keyring is put through an openwork shoe near the little toe on the affected side or two holes can be made in an ordinary shoe with a skewer allowing the keyring to be inserted. The elastic is placed through the keyring and runs up over the opposite shoulder and then back to the front of the body where it is held in place by a safety pin. The tension in the elastic is adjusted to lift the toe clear of the ground when walking. It can be tightened when the leg tires. A simple garter below the knee holds the elastic to the leg. Patients can also get their cobbler to attach a strap and ring across the toe of their shoe if they prefer.

This is much more helpful than the expensive appliances supported by the National Health Service, and can be bought cheaply by the patient's relatives.

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