To this end we have developed an indicator package which draws data from the health services authority 'Exeter' computer system, the Prescription Pricing Authority, the child health computer and general practitioners' own practice reports and feeds back these data to all local practices using a software package similar to that used for the health service indicators. These indicators have been well accepted by general practitioners and have attracted a great deal of interest at all levels of health service management. We hope to develop the indicators further and share the package with other health authorities to enable feedback of vulnerable information to those who deliver primary health care.

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Screening patients for alzheimers disease

Sir,
I read with interest the paper by Wilcock and colleagues on detecting patients with alzheimers disease suitable for drug treatment (January *Journal*, p.30). Having screened 246 patients, the authors ended up with one patient who may or may not have derived benefit from drug treatment for alzheimers disease. On this basis they conclude that every patient aged 75 years and over should be screened annually.

The initial screening may well not be particularly onerous, but the follow up of abnormal test results would involve considerably more time, and even the basic level of five minutes per patient per year would mean an extra 20 hours of work, which would have to come from somewhere.

The benefits of all this hard work appear to be marginal. While I am in favour of improving the quality of life of elderly patients, I feel that blanket screening is not the best way of doing this. Surely it would be better to target those patients in whom there is some suspicion of memory loss or confusion? This would usually become apparent during the normal annual check for those aged 75 years and over.

General practitioners have come under a lot of pressure recently to perform screening tests on the general population of little or no proven value, at the expense of providing care for the sick: this is another example.

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Value of health checks

Sir,
The February *Journal* was interesting with two articles on health checks: the British family heart study and the accompanying editorial by Mant (February *Journal*, p.62 and 51, respectively). Neither demonstrate nor quote evidence of mortality reduction. The value of such approaches seems to be accepted for the reduction of risk factors rather than of risk. The deleterious effects of such interventions on the individual, the population and on the doctor now obliged to carry out such strategies are entirely ignored.

In my practice at least three patients resuscitated following cardiac arrest outside hospital have survived between three and 10 years. It does not require a trial to establish the benefits of such a strategy on deaths from coronary heart disease yet the Royal College of General Practitioners and the government continue to encourage and promote unproven risk factor reduction (not the same as risk reduction) strategies, often limiting personal freedom, and engendering guilt. These additional pressures from academia and politics sap both enthusiasm and resources from local initiatives which are self evident in their effectiveness.

In his editorial (February *Journal*, p.50) McCormick refreshingly points out that judgement should be applied to even the most straightforward clinical situations. One can only hope that common sense triumphs over dogma.

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Judgement in medicine

Sir,
We have been treated to an editorial by the doyen of personal care James McCormick (February *Journal*, p.50). Are his words the distilled wisdom of a sage, or is he simply wearing 'judgement' like the emperor who wore his new clothes?

He states that exercising judgement requires experience that is 'patient specific and relies on knowledge of the individual'. There have been sentiments similar to Professor McCormick's recently expressed in an editorial in the *British Medical Journal*.[1] While these add to our feel-good factor and to the mountain of soft data, they will fail to impress the masters of our health service, nor will they give much support for the promoters of personal care.

What is needed is hard debate with robust data to resolve the profession's most puzzling conundrum. This is the paradox of our creed of personal care, and our action of marching resolutely in the opposite direction.

The hard data we have show that the primary health service we provide is from increasingly large health centres, is increasingly complex both technologically and managerially, and increasingly anonymous. The evidence is that this trend is continuing.[2] This direction is driven by the Minister of Health, the Department of Health, supported by many leading general practitioner intellectuals[3-5] and has the tacit support of the Royal College of General Practitioners and the British Medical Association. Interestingly, perhaps worryingly, there is increasing evidence suggesting that patients do not share this enthusiasm (Thomas KJ, *et al*, personal communication).[6,7]

If personal care is important then how important, and how will we ensure its place in the future National Health Service? One major benefit of the resolution of this paradox would be that the profession will no longer seduce bright, caring, young people only to have them suffer emotional atrophy, disillusionment and burnout.

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