done can local anaesthesia provide the surgical anaesthesia necessary for the wide range of minor surgery undertaken in general practitioners' surgeries.

Does not the general public deserve to be treated by a medical profession capable of alleviating the pain of minor surgery effectively and consistently? By incorporating the training of local anaesthetic skills into minor surgery courses, perhaps the quality of the surgical treatments offered to the public can be further improved.

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Sir,
We appreciate and welcome the editorial on training general practitioners in minor surgery (March *Journal,* p.103) and would like to widen the perspective. General practitioner training is only part, although an extremely important part, of a whole: patients not only require the skills of the general practitioners, but also high quality care through supporting services. This includes nurse input for patients' preparation, post-operative support and longer term care. In addition, the appropriate environment which provides safe standards for infection control and sterilization of equipment must not be overlooked.

Minor surgery must be considered within a total context of skilled doctors and nurses and the back up support that ensures patients' safety and a satisfactory outcome of care.

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Testing for depression

Sir,
Dr Wright (March *Journal,* p.132) is correct when he says that mental health screening questionnaires are rarely used by general practitioners. A postal survey of 171 general practitioners (one in two principals in Sheffield) produced a response rate of 81% (139), representing 40% of all general practitioner principals in Sheffield in May 1992. Of these 139 general practitioners, only 29 (21%) had ever used any kind of psychometric questionnaire. Of these, 45% used this type of questionnaire only once a year or less, and only 7% used a mental health questionnaire more than once a month (fewer than 2% of all respondents). The reason given for using such questionnaires was for help with diagnosis in 55% of cases.

This may have implications for postgraduate training, since general practitioner trainees are unlikely to use diagnostic questionnaires on a regular basis if they do not see trainers using such screening instruments. In my 1993 study of general practitioner detection of psychological distress, a cohort of 19 general practitioners with a database of more than 4000 patients used the 12-item general health questionnaire. In qualitative feedback data, no general practitioner found any faults with the questionnaire, several commenting on the fact that they felt that it had helped patients to present symptoms of anxiety or depression during the consultation. Perhaps continuing medical education courses could contribute to familiarizing general practitioners with the advantages and limitations of simple screening questionnaires, to the benefit of our patients and ourselves.

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Sir,
I found much of great interest in Wright's paper 'Should general practitioners be testing for depression?' (March *Journal,* p.132). We need to be careful about adopting too slavishly the diagnostic categories of our psychiatrist colleagues; in general practice the picture is never as simple as the rating scales make it look.

However, far more worrying is the problem of labelling patients who might wish at some time in the future to obtain life insurance. It has come to my notice that some life insurers, on seeing that a potential client has been reported by his or her general practitioner as having suffered from a depressive illness in the past, have loaded their premiums or even denied the client life insurance altogether.

For this reason we need to be careful, perhaps noting sadness, grief, or loss as the problem presenting, not depression as the diagnosis made. Certainly I think our patients would welcome this. Perhaps we ought to listen to their sadness and become more effective at helping them with grief and loss. Skilled counsellors can be helpful in assisting general practitioners in this work.

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Sir,
I read with interest the article by Wright (March *Journal,* p.132). I would like to reinforce the view that, in medicine in general and in psychiatry in particular, questionnaires and tests should only be used as adjuncts to enhance the diagnostic accuracy of the clinician and the results of questionnaires should not be relied on when deciding on the diagnosis of depression.

All physicians should realize the importance of the doctor–patient interview, and the empathic relationship that develops as a result, which is essential if the doctor is to gain an insight into a patient's thought processes. In the assessment of depression and suicide risk, this is particularly important. The doctor should observe the frowns, groans, expressions and titubations which develop and change as the interview progresses. A general practitioner is usually the first point of contact for a depressed patient seeking help, advice, assurance and comfort, and to ask the patient to complete a self-administered questionnaire at the first consultation may not be helpful. In addition, it may not be possible to expose the direct and indirect communication of suicide intent,[1] if patients are asked to declare their intent to a blank sheet of paper or a computer.

The prevalence of psychiatric illness in general practice is substantial[2] and the great majority of this morbidity comprises affective disorders.[3] Although all potential cases should perhaps have the benefit of specialist advice,[4] at present general practitioners have to deal with the bulk of identified psychiatric morbidity themselves. The issue of how psychiatrists can collaborate most effectively with primary care medical services therefore continues to be of immediate concern. The defeat depression campaign of the Royal College of Psychiatrists and the Royal College of General Practitioners, which aims to improve the recognition and management of depression by improving the skills of the doctor in the clinical interview,[5] is a step in the right direction.

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4. Arya DK. Should general practice refer more patients to hospital? *J R Soc Med* 1991; **84:** 759.
5. Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992; **305:** 1198-1202.

Sir,
We welcome Wright's discussion paper on testing for depression in general practice (March *Journal,* p.132) and support the call for the screening of high risk groups such as elderly patients. Brief assessment schedule depression cards (BASDEC) have been developed for this purpose and have been validated among elderly hospital inpatients.[1]

This screening instrument was applied to community patients as part of the annual health check for those aged 75 years and over by a general practitioner and trainee. It proved universally acceptable and, as patients performed the 3–4 minute test while notes were being written up, added little to total assessment time. Seven of 42 patients gave positive results when first tested. When these patients were retested after six weeks, four still had a positive result and were evaluated by their general practitioners. Three judged to be clinically depressed were managed accordingly; their brief assessment schedule depression card score improved with therapy.

This screening instrument can thus be used as part of annual health checks for 75+ year olds and yields a worthwhile number of patients with previously unidentified, treatable depression. We recommend its wider consideration.

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Euthanasia

Sir,
In his paper on euthanasia David Jeffrey explores this troubled aspect of dying (March *Journal,* p.136). I too believe that 'active euthanasia should be firmly rejected...'. I find it alarming to contemplate death as a management option. However, this is not the main bone of contention as expressed in Jeffrey's article, which is passive euthanasia, the reluctance to let people die.

Things used to be different. There was no life support; medical and surgical interventions were limited; the technical invasion was science fiction. Now miracles of modern medicine eclipse the mundane. Values are distorted at our peril. Death, like birth and life's other major milestones, is a natural target of the technical invasion. Events that should be mainly social have become mainly medical.

There can be no argument with the advances of medical science. The argument lies in their application. In this, medicine has no monopoly. Human nature properly dictates that the frontiers of all science, all knowledge, extend inexorably. However, an equivalent growth in wisdom is vital if the potential benefits of technology are to be realized. There are signs that wisdom is lagging far behind.

Could this be why children prefer arts to science? Is it a reaction to the technical invasion which makes nonsense of nature, humans and habitat?

Jeffrey's analysis is logical and comprehensive. Its synthesis is critically important — how to apply such complexity. At least three steps seem necessary to me. The first is to stop and think — too many are so busy doing, they rarely pause to reflect on the wisdom of their endeavours. The second is to take a broader view. Medicine has shared with other science an assault on the fragile fabric of human sensitivities at times of triumph and tragedy. New technologies need breaking in. Thirdly, as Jeffrey says, the synthesis has to have a human face.

The place of medicine in birth, life, and dying can never be set in stone. Not only does science change, societies differ and budgets constrain, but each person is unique. Each doctor and each patient has to grapple with events which defy their wishes. Each has to make decisions which are tempered by the law and by well honed beliefs. There will always be disputes. The reputation of our profession depends on our collective wisdom, each an ambassador of all.

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Summative assessment

Sir,
Miles Mack argues against compulsory summative assessment for general practitioner trainees (letter, April *Journal,* p.188). He evidently benefited by delaying sitting the MRCGP examination until after his traineeship, thereby avoiding a curriculum driven, examination oriented year. He enjoyed the flexibility and freedom to put together his own programme of training under the guidance of his trainer. He then took and passed the MRCGP examination so I presume he feels both the examination curriculum and the qualification are of some value in themselves. If so, I agree with him.

There needs to be a degree of flexibility in the timing of compulsory summative assessment. Just as aspiring general practitioners should be trusted to put together their own self-select training schemes, should they so desire, so they should be allowed to sit an assessment examination when they feel ready. Perhaps the only restriction could be that they pass it before admission to the principals list of a family health services authority. Compulsory summative assessment is important because we live in a world increasingly dominated by evaluators. It is a cogent way to show them that we have a mature and effective form of quality control.

We are not children and we do not need an end of year examination to justify ourselves to our teachers. We are, however, expecting to be regarded as competent professionals by our peers, paymasters and patients. If all new general practitioners can show a high degree of competence by obtaining MRCGP, our status as a specialty will be enhanced. Enhanced status will result in improved recruitment rather than the reverse.

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Assessing medical performance

Sir,
The article by Rethans and colleagues asks to what extent patients' notes reflect actual medical performance (April *Journal,* p.153). Their answer seems to affirm that 'the use of clinical notes to audit doctors' performance in Dutch general practice is invalid'. We dispute that this conclusion can be drawn from the study for two main reasons.

First, simulated patients used in the study were all, by definition, new patients. This is not the usual context in which general practitioners see most of their patients. This is important because contex-