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4. Arya DK. Should general practice refer more patients to hospital? *J R Soc Med* 1991; **84:** 759.
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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.

FIONA RAWLINSON
ANTONY JOHANSEN

Brynlea Hey
St Lythans Down
South Glamorgan CF5 6SB

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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.

HUGH CARPENTER

British Embassy Moscow
King Charles Street
London SW1A 2AH

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.

JIM GARDNER

Pinewood Cottage
Sedgwick
Cumbria LA8 0JP

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-