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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.

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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-

tual clues have been shown to be paramount in the diagnosis and management of clinical disorders in general practice.[1] Hence the conclusions about records are restricted to scenarios in which the context is limited to that provided only by the encounter. In such a situation doctors might reasonably choose one of two approaches to the contruction of a record for the new patient, either to be very thorough or to jot down what, in their view, were the essentials of the case with the expectation that the patient would be returning. Hence the consultations studied were biased both in type (new) and in content (lacking important contextual attributes).

The second reason is more complex and concerns the extent to which records are performances in their own right as well as reflections of another activity — the clinical encounter. The paper begs the question what is medical performance? Rethans and colleagues regard it as just what went on in the consultation, the interaction between doctor and patient. Of course medical performance is more than this. So what exactly is the performance being investigated, and upon which the notion of validity is founded; what is the record valid for?

To answer this question it is helpful to consider what type of validity is being investigated here. If content validity is being investigated, then surely the appropriate questions are either: is the content of the consultation, in terms of discrete descriptions of all actions, reflected in the record? (representativeness) — plainly it is not; is the record nevertheless accurate for what it did record? (fidelity) — these data are not presented.

The record is clearly content valid from the point of view that it exists (although many were missing), and also from the point of view that things get recorded in it as part of the performance of the doctor's duties. Perhaps the correlations should be regarded in the same way that multiple choice question, essay and clinical scores correlate in formal assessment systems. That is, they are different aspects of performance and contribute to the construct validity of clinical assessment. Looked at in this way the coefficients reported in the study are of an appropriate order of magnitude.

Criterion validity would be estimated, not by measuring how many of the whole number of events taking place were recorded, but by measuring how many of those events taking place in the consultations which should be recorded (according to standards) actually were. This is not addressed in the study because the standards were set for the interaction not the recording.

Furthermore, records may be used to assess the quantity of performance (for which they are plainly invalid), but they may also have a relationship to the quality of performance. Suppose, for example, that the correlation coefficient (index) calculated had been 1.0 or 0.9. This would mean that every or almost every action performed was recorded irrespective of its importance. Is this an indicator of high quality performance? Moreover, is it sensible, plausible or efficient?

The authors summarize that 'The finding that the mean content score for all the categories of actions ranged from 0.25 to 0.36 shows that little can be concluded from records about what doctors actually do during consultations'. This may be true but does it invalidate the record as an aspect of performance to be assessed? Does the record have to be verbatim to be an accurate reflection of the consultation? We would think not.

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Counselling children in general practice

Sir,

We were interested to read the editorial by Salinsky and Jenkins (May *Journal,* p. 194) discussing counselling in general practice. It is encouraging that practices are developing this service, but to date it has been directed mainly towards adults. Despite the fact that bereavement, adjustment to disability and anxiety are not exclusive to adults, some surveys of counsellors' functions in general practice make no mention of children.[1,2] Although counselling of adults is likely to be of indirect benefit to their children, counsellors must address the impact of adult mental health problems on parenting if this benefit is to be maximized. It is well known that mental health problems are common and underdiagnosed among children presenting in general practice.[3] While some of these children will require referral to specialist services, others may be helped in the primary care setting.

Dowrick's extensive review of mental health provision in primary care says little about children, but alongside a call for more cooperation between primary and secondary care in the field of mental health, he calls for a comprehensive audit to be carried out.[4] If we are to ensure that children's needs are adequately addressed, child mental health workers should make sure that they are part of this process.

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Detecting patients with alzheimers disease

Sir,

Dr Cross (letters, June *Journal,* p.283) expresses concern about additional work that would result from screening for dementia.[1] Checks for patients aged 75 years and over are being carried out already as part of general practitioners' terms of service, and screening for dementia is included in these. Deterioration of mental function should therefore be detectable as the checks are carried out annually and results can be compared with those of previous years. Early intervention can avoid crisis management and may save work in the long term. Some causes of dementia are treatable, for example, vitamin B_{12} deficiency, and it must be part of a general practitioner's function to detect these problems as early as possible.

Furthermore, Wilcock had expressed concern that tetrahydroaminoacridine (tacrine) might be used without discriminating clearly between those patients who would benefit from its use and those who would not. He also surmised that the number of patients who would benefit would be small. Our study proved him correct. In