nurses. One such criterion was that patients with heart failure, who are receiving more than frusemide 40mg, should also be receiving an ACE inhibitor. The audit consisted of 502 patients from 10 practices who were receiving diuretics. Of those patients who satisfied our agreed criterion for ACE inhibitors, 50% were receiving treatment that complied with the criterion.

These are early days for the dissemination of recently published science to the profession, and we in Barking and Havering are to take this audit further during the current year in order to improve the management and investigation of cardiac failure in our locality.

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Managing drug abuse

Sir,
The timely paper by Hindler *et al* on drug misusers' perception of general practitioner care (March *Journal* p149), draws attention to GPs' lack of confidence in their ability to manage drug misuse and to the need for specific training for GPs in the subject. However, opiate abuse is not a popular subject with most GPs[1] and is unlikely to attract a large number for even a day's study. However, a programme incorporating it into the wider aspects of addictive behaviours should not only draw more participants, but should also be of much greater value to a larger number of patients.

If such courses are to reflect the average general practitioner's caseload, they should focus on the most common drugs of dependence — nicotine and alcohol, as well as illicit drugs. Furthermore, substance abuse is only part of a much broader spectrum of related addictive behaviours[2] seen in general practice, including bulimia, self-harm, sexual disinhibitions, shoplifting and pathological gambling. To include teaching on treating opiate abuse within this broader menu might encourage more GPs to engage with this group of drug users more effectively.

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Patient satisfaction

Sir,
Clare Bradley (April 1996 *Journal,* p.253) makes a number of critical points about our patient satisfaction questionnaire (October 1995 *Journal,* p.525).

Her first criticism is that the questionnaire items were generated from a restricted sample. We disagree. Respondents came from a variety of practices in different areas. The Manchester and Leeds respondents came from 14 practices in urban and rural areas. The Norfolk respondents were chosen, and interviewed by, *patients* at one practice, to encourage free expression of (dis)satisfaction from respondents. We have no way of knowing which practices they belonged to, since the procedure was carried out anonymously, although interviewers were encouraged to question patients from other practices. Interview questions were derived from the literature on factors likely to predict satisfaction and dissatisfaction, to ensure that all potential sources of (dis)satisfaction were covered.

Her second concern relates to the use of one general practice to determine which items formed the final version of the patients satisfaction questionnaire. We are currently checking the reliability and validity of the final version of the scale in eight practices across Britain. Results so far suggest that the scale is reliable and valid for use in all these practices.

Her third comment concerns the criteria that should be used to select the best items for a patient satisfaction measure. Whilst we would agree with her that one aim of patient satisfaction measures is to identify problems with services, we cannot agree that the best procedure to achieve this is the selection of items skewed towards dissatisfaction. A scale composed of items on which there is a range of views is more appropriate. If most respondents agree with an item, the scale is unlikely to be sufficiently sensitive to pick up differences in satisfaction between patient groups, or changes over time. Whilst we removed a number of items because of skewness this was almost exclusively because of items being skewed towards satisfaction (54 out of 55 discarded items). The items Bradley would have us use were simply not present, probably because of the commonly acknowledged bias towards positive views of general practice. Practices involved in testing the questionnaire have found the free-response space at the end of the questionnaire (where patients are asked to list good and bad points about the practice) useful in validating the quantitative data, and in identifying idiosyncratic problems in a practice.

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Detecting depression in the elderly - what will improve our performance?

Sir,
Data from my research support the findings which Tylee and Katona summarise (April *Journal*): that general practitioners are less accurate in their assessment of the mental health of patients aged 65 or over than they are for younger age groups. However, evaluation of an educational intervention to improve GP detection of