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

psychological distress[1] suggests that it is in such subgroups of the population that GPs can improve their performance. Work in our own practice also supports the feasibility of the Geriatric Depression Scale for use by practice nurses in screening assessment. However, the use of mental health-screening questionnaires in primary care remains uncommon.[2] If there is pressing evidence of underperformance, therapies available, and effective trainings[1,3] and instruments that exist which can improve detection, we must consider why primary care teams fail to avail themselves of these options. Several possibilities exist: the evidence has failed to reach them, the resources required (such as time with patients, time for training, drug budgets) are lacking, or there is attitudinal resistance from either staff or patients.

I would support the editorial's emphasis on the need to focus both research and training on the practice team, and new educational initiatives which encourage more active participation in planning our continuing professional development[4] may be helpful here. However, in recent education meetings within our own practice, we have had evidence of 'cultural clashes', in that many staff perceive increased medication (whether for depression or lipid-lowering!) as a further medicalization of a society which is becoming unacceptable. Some of these attitudes are echoed by the patients, who may prefer the 'listening ear'; indeed, some of the undertreatment mentioned earlier is known to relate to non-acceptance by patients. Those of us who engage with practice-based education will therefore need to accept a considerable level of 'critical dialogue'[5] with our peers, concerning not only specific trainings and treatments, but also the whole concept of evidence-based medicine, resource allocation, and the different professional attitudes of doctors, nurses, and practice counsellors. I would hope that the RCGP would support more evaluative research into the realities of practice-based education.

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Mental health care professionals and general practice

Sir,

Roslyn Corney's paper (April *Journal*) regarding the links between mental health care professionals and general practices attempted to address important questions. However, it appeared flawed in several ways.

As the paper was based upon a cross-sectional sample of practices rather than a longitudinal study, there was no evidence to support the assertion that practices changed *as a result of* fundholding. While it does appear that current fundholders have greater contact with specialist services, these links may have developed before the practices sampled became fundholding.

Furthermore, the concluding statement of the summary, that increasing treatment options to certain patients may reduce services available to people with long-term and severe mental illness, may be true, but was not, from this paper, evidence-based.

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Asthma in the community and in general practice

Sir,

We were interested to read the recent papers by Tirimanna *et al* and Frank *et al* (May *Journal,* p277 and p295), in which the population prevalence of asthma/COPD of 31% in the Dutch study is remarkably similar to that of reported wheezing (30.4%) in the British study undertaken in Manchester. While Tirimanna and colleagues commented that the high prevalence of asthma/COPD was likely to be due to a large number of people with very mild symptoms, Frank *et al* used a symptom scoring system to define a sub-population (13.8% of all subjects) who were judged possibly to have an asthma-like illness.

We have recently analysed data from 3 169 subjects aged between 29 and 69 years, randomly selected from six general practices on Teeside. We also found precisely the same prevalence of reported wheezing (30.5%, 95% confidence interval = 28.8–32.0), but (based on further questions concerning whether the subjects suffered from any four of the following: wheezing in the past 12 months, waking with a feeling of chest tightness, waking with shortness of breath, waking with an attack of coughing, or having hayfever), we found that only 6.6% (5.7–7.5) had an asthma-like illness, compared with 13.8% (13.0–14.5) as reported in Frank *et al's* paper.

We are concerned that both reported studies have overestimated the community prevalence of asthma; for example, only 9.6% (8.1–11.1) of our patients, compared with 14.1% (13.4–14.9) in Frank *et al's* study, woke during the night with shortness of breath. This symptom is a good predictor of response to histamine challenge testing, and this result appears to indicate that the prevalence of bronchial hyper responsiveness (BHR) is different in the two studies. Using the definition of BHR recommended by Burney *et al,* who validated the EC questionnaire, we found that 13.9% (13.5-14.3) of our sample had BHR, but of those who were BHR positive only 60.9% identified themselves as either having had an attack of asthma in the previous years, or taking medicine for asthma. Although we were unable to detect a gender effect, our results for smoking were similar to those of Frank *et al*; the odds ratio for asthma in smokers is 1.82 (1.34–2.45, $P<0.001$).

Without careful validation of postal questionnaires against respiratory function testing, it is difficult to be sure which are the 'best' measures of the community prevalence of asthma, or how to interpret and compare prevalence, time-trend and national history studies.

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Saving money in general practice

Sir,

Dr J Hill-Smith in his article (May *Journal,* p.271) has shown very clearly that, if a group of interested GPs spend time and gather together in the company of experts on therapeutics, they can