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

improve their prescribing and save money. He also gives a good account of the mechanics of creating a formulary for their use. However, the summary of the article says that the 'estimated saving resulting from the creation of the formulary was £150 000 (£3000 per doctor) per year.' There is no evidence in the article that it was the creation of a formulary rather than the hard work of a number of doctors that caused the money to be saved. Others have saved money without formularies.

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Summative assessment for GP registrars

Sir,
Dr Grant's letter on behalf of the Tayside Trainers (June, p373) surprised us, as all of the issues raised have been widely discussed and debated. Perhaps talking to their neighbouring region could have prevented the concern. The first point was about insufficient consultation: widespread consultation took place via the Joint Committee and the UK. Advisers as early as 1992, and our original paper[1] appeared in the College *Journal* in 1993. The only part which has changed since that paper is the detail of the trainers' report and this is a change which we are sure the trainers welcome. The second point concerned a challenge to the process. This has already taken place within the West of Scotland and the system has been fully operational since August 1993. Our experience has been passed to the other regions and we have also been responsible for training the other regional assessors in the various techniques. Sixteen publications have appeared in the peer-referenced literature, which includes correspondence in the learned journals related to these publications. Under 'Critical Reading Policy' the Tayside trainers criteria states 'selecting relevant medical literature as part of keeping abreast of developments in medicine': in view of this, the lack of knowledge of summative assessment is surprising.

As far as the MCQ is concerned, it would be logical to use the multiple choice paper of the MRCGP in summative assessment. We approached the College in 1993 to see if this was possible and indeed we ran a pilot study together. However, the College refused further use of the question bank and would only permit the use of the MCQ by candidates taking the whole exam. In the absence of an alternative test of factual knowledge, this would mean that the MRCGP exam would be compulsory for all prospective GPs. As a result, we approached the Royal Australian College of General Practitioners who agreed to provide the UK Advisers with their question bank. The major difference between the question banks is that the MRCGP exam contains more items on epidemiology, research methods and administration than that in use for summative assessment. Since the summative assessment paper is about minimum competence, we would suggest that this is appropriate. The UK Advisers' exam has now been taken by over 1000 candidates with a pass rate of 97% and a pass mark carefully set at the level of minimum acceptable competence. Details of setting the pass mark are in press.[2]

In addition, it is worth noting that the RACGP exam has published reliability data on its exam which the UK College has never done.[3]

The next point regarding sufficient assessors is puzzling, as the number of people who attended our preparatory courses from Tayside was way in excess of their regional requirements. Regional Advisers have also worked very hard in identifying funding for the delivery system. The concern about summative assessment dominating the GP registrar year is unfounded, but there is no doubt that the GP registrars will be concerned if trainers are unaware of the process. Summative assessment is about minimal competence, and the content is based on the work of a general practitioner and should not in any way interfere with the GP registrar year. To deliver the various components, however, personal organisation is important and planning is required throughout the year.

We agree with the final point regarding medico-political and educational manoeuvrings being frankly unacceptable: at present the only provider of a complete package of summative assessment is the UK Conference of Regional Advisers, and their concern about standards. However, the Regional Advisers have had a high degree of co-operation from the GMSC, RCGP and JCPTGP. We hope the Tayside trainers are reassured by the facts. It is important that our discipline has a credible entry standard for independent practice and summative assessment will provide that.

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Psychiatric illness in General Practice

Sir,
With regard to the editorial in the June issue of our *Journal* (page 327–328) concerning the identification of psychiatric illness in general practice. I think the time is about ripe to introduce some totally new ideas about mental health into general practice.

Until now our guiding light has come from the psychiatrist, who believes that mental illness is something that is wrong with the brain. By and large we are taught that all psychiatric disorders are due to a deficiency of drugs. What is missing is scientific data concerning the mind as opposed to the brain.

We talk of body, mind and spirit, and then make the assumption that the mind is a function of the brain and the soul or spirit is some sort of electric circuit in the frontal lobes of the brain. In other words, we reduce the parameters of science to that of the body, with its brain and with its higher centres of the brain; i.e. body, body and body.

Looked at in these rather harsh terms, we find ourselves stuck down a cul-de-sac which leads nowhere.

Scientific data does now exist concerning the mind and the mechanisms of mental aberration in a subject called dianetics. Perhaps our *Journal* could bring this fact to the attention of the practising GP.

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Chronic pain in dementia – underdetected or undertreated?

Sir,
Although about 4000 papers are produced annually on the subject of pain, less than 1% are confined to older people.[1] Pain is