choose to hear, or want to hear: GPs' opinions may have been more equivocal than families state! But it would be greatly appreciated if GPs could make the time to obtain and read the Continuing Care criteria, so that they are in a position to give as informed a view as possible regarding this important matter. We have a shared task, to ensure that those who are eligible for the full funding of their care are enabled to obtain this help as speedily and as easily as possible.

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SAGA magazine. January 2005.

Prescribing to substance misusers

I must strongly disagree with Stephen Willott's opinion[1] that it is 'good news' that there has been an almost threefold increase in the number of GPs seeing opiate users.

If there had been an increase in the proportion of substance misusers seeing GPs and having specific treatment (from someone) that would be good news.

The possibility of a real increase in the number of misusers would most definitely be bad news, whether or not they were seeing their GP!

Again, increase in proportion treated (regardless of numbers) would be good news, but that they are treated by inexperienced non-specialists would not necessarily.

An increase in the number of GPs seeing these patients, even if the total patients stays the same, would imply that they are being more thinly spread across non-specialist care, and this suggests to me that their care is being dumped on inexperienced GPs who do not have the support to manage them well.

This would most definitely not be good news for the patients or the community.

It is also quite possible that they are indeed being dumped without the provision of any local enhanced service support, and this would be bad news for the GPs involved, who are doing it for free, as well as without support.

I don't know where Stephen works, but here in our part of Wales we have very poor availability of service, partly related to rurality, but the hospitals do tend to discharge such patients with instructions to get scripts from their GPs for tomorrow's doses, with no thought as to the effects of this on GP services or quality of care, and the fact that we have no contract to provide such services. Furthermore, when informed of their duty to continue prescribing, the hospital staff seem to think it is okay just to dump it for GPs to sort out, when we don't even have access to a suitable dispensing chemist for some of these drugs nearby, let alone education and an LES for the service.

Could Dr Willott influence this service provision problem at all to improve care of these patients?

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REFERENCE

1. Willot S. Prescribing to substance misusers [letter]. *Br J Gen Pract* 2005; **55:** 638.

Mental health screening may prove effective in primary care

A recent study by the MaGPIe Research Group[1] demonstrated high GP recognition rates (70.3%) of mental health problems. The findings may, however, be biased by the fact that GP case identification was based on a historical 12-month observation period whereas the final diagnosis (CIDI) was a present state assessment (within 1 month). This could lead to an overestimation of GP recognition rates. The conclusion that there is little gain from screening due to high detection rates may therefore be erroneous.

In a study using a composite screening questionnaire[2,3] we found that 43% of patients had high screening scores. Among patients with high screening scores we found an NNT (number needed to test) of 5, indicating that feedback on high scorers has the potential to identify 20 new cases per 100 cases. The effectiveness of feeding back high scorers' results on depression and anxiety scales is supported by a systematic review by Gilbody and colleagues.[4] A clinically useful description of this high score group could provide us with suggestions for making rational use of rating scales in general practice. While there is little evidence to support routine mental health screening, case-finding seems most promising.[5]

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REFERENCES

1. The MaGPie Research Group. The effectiveness of case-finding for mental health problems in primary care. *Br J Gen Pract* 2005; **55:** 665–669.
2. Christensen KS, Toft T, Frostholm L, *et al.* The FIP study: a randomised, controlled trial of screening and recognition of psychiatric disorders. *Br J Gen Pract* 2003; **53:** 758–763.
3. Christensen KS, Fink P, Toft T, *et al.* A brief case-finding questionnaire for common mental disorders: the CMDQ. *Fam Pract* 2005; **22:** 448–457.
4. Gilbody SM, OHouse A, Sheldon TA. Routinely administered questionnaires for depression and anxiety: systematic review. *BMJ* 2001; **322:** 406–409.
5. Christensen KS, Toft T, Frostholm L, *et al.* Screening for common mental disorders: who will benefit? Results from a randomised clinical trial. *Fam Pract* 2005; **22:** 428–434.

Impact of obesity

The Counterweight Project Team documented the obvious in their paper 'The impact of obesity on drug prescribing in primary care':[1] physical activity and weight loss produce better health and save money of the tax payers.

In the US, CDC has estimated that a sustained 10% weight loss will reduce an overweight person's lifetime medical costs by $2200–5300 by lowering costs associated with hypertension, type 2 diabetes, heart disease, stroke and high cholesterol.

This does not take into account other resources consumed by problems such as orthopaedic related issues.

Prevention by means of lifestyle education is of paramount importance.

Upon this point of view, I wonder why GPs do not get 'points' on the basis of the results achieved in controlling the BMI of the patients in their list.

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REFERENCE

1. Counterweight Project Team. The impact of obesity on drug prescribing in primary care. *Br J Gen Pract* 2005: **55;** 743–749.

The law on assisted dying

I would like to point out that an opposition to a change in the law on assisted dying simply perpetuates an injustice of great magnitude, that it effects a small minority of patients with terminal disease is no reason to shirk from the truth. Usually the courageous are those who struggle against the status quo rather than those maintaining it.[1] This is amply illustrated by two contrasting and well publicised judgements, that of Ms B,[2] a ventilator-dependent woman, the other of Diane Pretty,[3] the woman with motor neurone disease who wanted immunity from prosecution for her husband so he could assist in her suicide.

Two points can be drawn from these cases. The first arises when one asks why switching off a ventilator on a ventilator-dependent patient is not consistent with the offence of assisting a suicide? How can a patient request removal of a treatment where the inevitable consequence is death, and this not be regarded as a request for suicide? The answer, in law, lies in an unsupported statement made by Lord Goff in the Bland judgment, 'I wish to add … there is no question of the patient having committed suicide nor therefore of the doctor having aided or abetted him in doing so'.[4]

The second point is that both these women were rendered disabled by, from their point of view, a random event. Why should one be allowed her desire for death when the other is discriminated against? Insult can be added to injury for the family of Diane Pretty by a recent case involving a woman, also with an incurable degenerative neurological condition, who had an injunction preventing her leaving the country quashed by the court.[5] She needed her husband's help to get to Switzerland so she could be assisted by him in committing suicide. The judge admitted that her husband would be in breach of the Suicide Act by taking her, given that this constitutes aiding, abetting or procuring her suicide, but that he would not recommend prosecution as it would not be in the public interest.

Diane Pretty had no option but to suffer, there may be a lesson to be learnt from Clifts[6] mysterious value of suffering, but it will not be found by questioning the patient but in examining the unethical way the law decides who shall be granted their ultimate desire and whom shall not.

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REFERENCES

1. Gerrard J. Assisted suicide [letters]. *Br J Gen Pract* 2005; **55:** 883.
2. Ms B v An NHS Hospital Trust (2002) 2 All ER 449.
3. Pretty v United kingdom (2002) 35 EHRR 1.
4. Airedale NHS Trust v Bland (1993) 1 All ER 821 at p 866 f.
5. Re Z (An Adult: capacity) (2004) EWHC 2817 FAM.
6. Clift A. Assisted suicide [letters]. *Br J Gen Pract* 2005; **55:** 883–884.

Assisted suicide

Thank you for publishing the letter by F van Veen-Zwart in November's Journal.[1] We must learn from events like this. Questions are:

1. Why couldn't the hospital have given him a supply (say five) of sleeping tablets?
2. Why couldn't the hospital have arranged for a supply of oxygen to be delivered to his home?
3. Why couldn't the hospital have arranged a night sitter for the weekend?
4. Why was he told the Macmillan nurse would be with him on Monday whan she only arrived on Wednesday?
5. Why coudn't the night sitter be arranged for 7 days a week?
6. Why was the night sitter not allowed to have anything to do with the medication?
7. Why was the medication not given correctly on the Friday night (no oramorph, no diazepam)?
8. Why was a syringe driver not forthcoming on the Saturday?
9. Why was there a problem with the diamorphine dose and why did it take so long to sort it out?

We need answers, though many can be guessed:

1, 5 & 6: Regulations applied needlessly and even callously;
2, 3 & 7: Regulations may need to be changed;
4 & 7: Liason between different parts of the the service is still poor;
8 & 9: Professional functioning needs to be tightened up (nurses 8, doctors 9).

Overall, things don't seem to have worked too well at weekends.

Do I have an interest? Of course I do, having spent a lifetime in general practice, and now having been retired 10 years and therefore nearer to needing these services myself. Things seem very similar to those I battled with. Fighting and ignoring or overturning needless and inhumane rules are an essential part of a GP's life. I still miss it!

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REFERENCE

1. Van Veen-Zwart F. Assisted suicide [letters]. *Br J Gen Pract* 2005; **55:** 883.

Note

Elwyn G, Lewis M, Hutchings H. Using a 'peer assessment questionnaire' in primary medical care. *Br J Gen Pract* 2005; **55:** 690–695.

For readers trying to find the American Board of Internal Medicine (ABIM) peer quesionnaire as mentioned in the article above, this is now available from http://www.abim.org/resources/publications/