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Comment from the Editor

The *BJGP* would never knowingly publish a spoof, and we hope we have not been party to publishing pretend research. However, this letter appears to ask a 'have you stopped beating your wife?' question. Either we are guilty of relaxing our critical standards, or we have been taken in by a spoof. Not very comfortable, in either case.

David Jewell

Jury service

I was pleased to read that on the whole Paul Head found his jury service an enjoyable experience.[1] Personally, I dread being called and indeed as a practice my partners and I have taken out an insurance in case of such an eventuality. I was also given a useful bit of advice by a solicitor of my acquaintance: when called for jury service start to cultivate a little Hitler moustache and turn up on the day in a pin-striped suit with a copy of the *Telegraph* under your arm. The defendant will quickly reject you as a potential juror. Clearly, this will not work for my female colleagues but perhaps they could dress up as Mary Whitehouse?

Richard Jenkinson
Burton Medical Centre, Burton, Christchurch, Dorset.
E-mail: Richard.Jenkinson@dorset.nhs.uk

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Embracing clinical supervision

Regarding John Launer's piece on embracing clinical supervision,[1] may I make the following suggestions? They are based on my experience of facilitating the development of a monthly 2-hour 'clinical peer review meeting' held within our practice on a Friday morning between 8 and 10am, and attended by all partners not on leave and some practice and district nurses. Many practices have been running such meetings for years, under various different guises.

- The agenda for such meetings should be wholly owned by the participants, and have no political drivers.
- The educational content should be developed by and mainly delivered by the participants.
- GPs should recognise the wealth of collective educational value they have within themselves. Once allowed to express it, even a small group of GPs has an abundance of hidden talents, skills and latent knowledge, and those deriving from areas beyond medicine should also be encouraged.
- A multiplicity of styles of delivery should be welcomed, and no norm expected.
- Departments of postgraduate GP education could help most by delivering funding for locum cover where possible.

Jeremey Meadows
GP Principal, Chessel Practice, Bitterne, Southampton.
E-mail: jeremymeadows@waitrose.com

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The article 'Moving on from Balint' by Dr John Launer, that appeared as an Editorial in the last issue of *BJGP*[1] is very timely and forward looking. I had the privilege of taking part in GP seminar's run by the Tavistock Clinic, for nearly 13 years. Through attending and taking active part in this professional development my quality of consultation and communication skills improved a great deal. At these seminars we had the benefit of a very senior and experienced psychoanalyst as the group leader, who helped us to discuss all the aspects of the case. During the time of my attending the seminar we also studied the pattern of referral to the hospitals, accidents and injuries. In the group we mainly discussed the patients who had psychological problems, but during the course of the discussion we also had the chance to see the recent developments, and evidence-based medicine as the discussion of the case progressed and the way it unfolded. In my mind I cannot think of any better form of supervision than these seminar's, where your management of the case is scrutinised, the presenting doctor is grilled, and applauded as well for some innovative ideas.

It is sad to note that these Balint groups are virtually defunct. Perhaps we have moved very fast with modern technology that doctors do not understand their patients, let alone the illness.

Suresh Pathak
GP, 84 Parkway, Romford, Essex.
E-mail: skpathak137@aol.com

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Short screening tools for depression

We read with interest the recently published paper on pooled analysis of ultra-short screening tools for depression.[1] In our view the issue of importance is the validity rather than the accuracy of the short screening test. A high false-positive rate is not as important an issue in initial screening for depression as it is when screening for conditions that require invasive investigations to establish the diagnosis (for example carcinoma of the breast). A few more questions is all that is required to establish a diagnosis of depression and then offer treatment. The authors refer to our more recent tool, the two questions with help question (TQWHQ).[2] A positive response to either depression question plus the help question gave a sensitivity of 96% and