

family or household appears on the screen every time an individual patient consults?.

Our simulation shows that it can take several years to screen the whole practice population by this method. This is because many patients will not visit their general practitioner and are therefore not available to be 'picked up' opportunistically. When they do consult their general practitioner they may not be invited into a screening programme, or be screened on the spot, for a variety of reasons. Results from an Oxford practice, which invited patients opportunistically to attend a health check, support this view.² After two and a half years only 25% of the target population had attended a health check. This was despite the fact that 94% of those invited to attend a health check did so. To reiterate our argument, the factor limiting performance is not patient compliance with an invitation to attend a screening appointment, but the proportion of patients who actually receive an invitation by the opportunistic method.

Baker may believe that this performance can be improved on by the use of appropriate computer software during the consultation. Indeed, we are sympathetic to this approach which exploits the computer's ability to act as a reliable prompt; though we regard its use as unproven. In our previous research³ we had to conclude that general practices that said they were using their computer system to carry out opportunistic screening were not achieving high screening levels, and that those with formal call and recall programmes were doing better. Of course, better software now exists, and with the new contract practices may be more motivated, but the case is not proven. In particular, the use of family and household links to improve coverage would be well worth investigating, although the individual patient would still need to make a personal attendance — 'surrogate' screening could not be considered adequate. Dr Baker indicates that he is carrying out a study in this area. We would welcome the results.

In the meantime, results from our simulation model coincide with those from actual screening programmes, strongly suggesting that adequate target population coverage is unlikely to be achieved through the use of opportunistic methods alone, without supplement by more formal invitation methods.

PAUL NORMAN
MIKE FITTER

MRC/ESRC SAPU
Department of Psychology
University of Sheffield
Sheffield S10 2TN

References

1. Norman P, Fitter M. The potential and limitations of opportunistic screening: data from a computer simulation of a general practice screening programme. *Br J Gen Pract* 1999; 41: 188-191.
2. Sacks G, Marsden R. Evaluation of a practice-based programme of health checks: financial costs and success at risk detection. *J R Coll Gen Pract* 1989; 39: 369-372.
3. Fitter MJ, Garber JR, Herzmark GA, Robinson D. *A prescription for change: a report on the longer term use and development of computers in general practice*. London: HMSO, 1986.

Spirituality, healing and medicine

Sir,

The review article on spirituality, healing and medicine (*October Journal*, p.425) was clearly thoroughly researched. It illustrated the inadequacy of the usual formula encouraging doctors to make a diagnosis in physical, psychological and social terms, if this results in the omission of a spiritual dimension.

I was unhappy, however, at the way in which christian healing was described. I feel that in attempting to provide a brief overview of healing Dr Aldridge obscured several important distinctions. The same confusion exists within the christian church where there is sometimes no clear distinction made between 'spiritual' or 'psychic' healing on the one hand and christian healing on the other. The former is usually characterized by magical rituals or trance-like states and an emphasis on specially-gifted individuals. Christian healing emphasizes the power of God to heal soul and body through Christ. This power can be released by faith and mediated by prayer and the laying on of hands, or by a word of command: 'In the name of Jesus Christ, get up and walk'. Some people may be more effective than others in bringing healing, since this type of healing comes from God, and is brought through whom God chooses.

It is also important for doctors to realize that people with a keen interest in spiritual matters are likely to have different objectives to their own in dealing with a sick person. A christian healer may have a desire to ensure the person's eternal salvation through faith in Christ, in the expectation that this will have the side effect of greater well being in this life. A spiritual healer might express the wish to bring harmony and peace to the person.

Medicine will be more acceptable and therefore more likely to be effective where it takes account of the patient's belief system and is able to be integrated within that system. I hope that more doctors will take this into account and as a result

perhaps more information will come to light as to the effect of various spiritual attitudes and interventions on health.

T G HEYES

Darton Health Centre
Church Street
Darton
Barnsley S75 5HQ

Community care of psychiatric patients

Sir,

Dr Horder's editorial (*October Journal*, p.399) was admirably thorough. I was particularly pleased to read discussion of the questions of general practitioner workload and remuneration, as these are linked to the quality of care provided to these patients, and the ultimate success of their life outside mental hospital.

I act as medical officer to a 30-bed private psychiatric nursing home, and agree with Dr Horder's conclusions about the resulting workload. There is a lot of paperwork and telephoning, but a surprisingly small amount of extra clinical work in terms of surgery attendances and visits. The monthly repeat prescriptions represent an onerous task, and would be almost impossible without a computer. As well as capitation and registration fees I am paid a retainer of £1000 per annum by the proprietor. A more realistic financial reward would be a clinical assistant fee for one or two sessions paid by the health authority. This should be possible, especially given the recent pronouncement by a House of Commons select committee concerning the responsibility of the National Health Service for nursing home fees.¹

Another problem is one of attitudes. Planners assume that general practitioners will take on the 24-hour care of discharged patients. Some members of hospital-based psychiatric teams have reservations about the standard of care provided in the community and feel that general practitioners are not competent in psychiatry. Given these attitudes further discussion is required regarding the role of the hospital and the community in the care of psychiatric patients.

V P SMITH

Lyngford Park Surgery
Fletcher Close
Taunton
Somerset TA2 8SQ

Reference

1. Anonymous. NHS must pay nursing home fees [news item]. *BMJ* 1991; 303: 1285-1286.