vide rubrics that relate appropriately to each component of the statement. The structure of the classification provides access to the various dimensions of the problem for formal analysis. In this example it would permit the collection of data on the effect of negative self-esteem in dementia, the coping behaviour of wives towards demented spouses and the value of domiciliary observations by community psychiatric nurses. The statement also remains available in free text as a poignant observation of a human tragedy.

Those concerned should assess the potential of the new edition of the Read classification before drawing conclusions about the rival virtues of the available classifications. The choice of the Read classification by the Department of Health as the standard in primary care may turn out to be more imaginative than Sharp and King suppose.

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Sir,
I read with some dismay the editorial by Drs Sharp and King (September *Journal,* p.356). General practitioners, and doctors in general, appear to be very concerned with classifying everything they come across. In the seven years since I became a principal in practice I have gradually discarded the medical model of psychiatric disease and adopted the counselling model. Using this model one soon realizes that most of the patients one sees are not ill in the medical sense, so it is not surprising that they do not fit into the categories defined for them by doctors. Their illnesses are a product of behaviour patterns learnt during childhood and the stresses experienced during their lives. Helping patients to unravel some of the underlying problems is an exciting challenge with remarkably good results.

It is entirely practical to undertake this kind of work in general practice and in my experience it often saves time in the long run and makes patients feel that they have achieved something. It is not possible without adequate support and in the practice where I work community psychiatric nurses are used to the fullest possible extent and we have direct liaison with counsellors in private practice. We also make full use of other counselling agencies such as 'Cruse'.

It is time that we stopped medicalizing 'behavioural' problems, understood the psychological factors producing them and started to recognize their origin and to treat them appropriately. Patients are individuals. How can they possibly be classified when the influences upon them are so varied and so personal?

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Adverse effects of screening

Sir,
The College does many useful things but perhaps the most useful is to encourage general practitioners to have a scientific approach towards their work. Karl Popper, the philosopher of science, has cogently argued that the basis of the scientific method is the forming of hypotheses and then testing them in a rigorous manner. It was obviously necessary that prior to the accumulation of sufficient well researched data the College's view on what was 'good' general practice was of necessity based on intuitive feeling. I would certainly have agreed that it was right 'to encourage the development of health promotion and preventive services in the practices of its members'[1] and it can be no coincidence that the government is planning to compel all doctors to screen their patients.

However, in my own practice I have become increasingly concerned about the adverse effects that various screening procedures have upon patients' well-being. My unease was strengthened by reading Dr Stoate's article (May *Journal,* p.193) and the harm that screening can do was further emphasized by Marteau in the *British Medical Journal.*[2]

It seems clear that we have underestimated the harm of screening. For some diseases (for example, carcinoma of the cervix) the benefit might outweigh the costs but general screening seems a most dubious activity. It is not yet proven to do harm but it certainly has not been proven to do good.

If we wish to be regarded as a scientific body then surely it is our duty to reject the hypothesis — screening is good for you — when investigative science suggests the contrary. If we do not do so, then we are as locked in our dogma as mediaeval astronomy was.

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Treatment of asthma

Sir,
Dr Brogan's letter sows seeds of doubt about the appropriate treatment of asthma (September *Journal,* p.390). However, there are answers to many of the questions he poses. Underdiagnosis does matter since in the absence of a diagnosis of asthma in children, very few will receive specific therapy and it is the use of suppressive treatment in the form of cromoglycate or inhaled steroids which can dramatically reduce time lost from school.[1] Adequate treatment also matters. Published surveys of asthma deaths in the UK invariably comment on the under use of available therapy because both doctor and patient failed to assess the severity of symptoms adequately.

Evidence has now emerged of preventable morbidity as a result of undertreatment of adult asthmatics. After an episode of acute asthma, patients who were treated less intensively in hospital and who were less likely to be sent home on inhaled steroids or reviewed subsequently, reported significantly more symptoms of poorly controlled asthma a fortnight after discharge and were 10 times more likely to be readmitted with acute asthma within a year than those who received more intensive treatment initially.[2] Indeed, in the same survey, a separate analysis of readmitted patients showed that the underuse of oral steroids immediately after discharge from hospital and of inhaled steroids in the medium term were the main predictors of readmission (Bucknall FE, *et al.* Factors predicting hospital readmission with acute asthma. Presented at Scottish Thoracic meeting, summer 1988).

Asthma is probably the most common chronic symptomatic disease in the community with as many as 60% of asthmatics suffering regular daily symptoms.[3,4] Yet perhaps only half of these patients currently receive regular treatment in the absence of a structured management plan within a practice.[4]

There are questions which remain unanswered but the case for treating patients with current symptoms of asthma in a rational manner is proven.

People with symptomatic asthma should be allowed the possibility of safe

and effective treatment in order that they may escape the sick role in which they find themselves.

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The exceptional potential of the consultation revisited

Sir,
Dr Middleton (September *Journal*, p.383) has attempted to update the framework published over 10 years ago with a skills centred framework relating to the patients' agenda, the doctors' agenda and a 'negotiated' plan.[1] I found his review concise and relevant to the work of the general practitioner. Nevertheless I was disappointed on two accounts. First, like many other commentators on our framework of the consultation, Dr Middleton omitted an important review of the relevant literature in 1983 which amplified and developed the ideas encapsulated in the original framework.[2] In this academic monograph the issues which the Cardiff framework raised were considered in depth including negotiated plans and the dual agenda approach to the general practice consultation.

The second cause of concern is the omission of an ethical dimension. The ethics of the consultation and the doctor–patient relationship will be brought into sharp relief if the new contract is imposed on us in April 1990. The issue is considered in some detail in the same monograph in a chapter entitled 'The refuge: ethics, practices and problems' and I would urge any serious scholars of the consultation in general practice to consider the content of that chapter in the light of what will happen to us if the government has its way in the 1990s. Never before have general practitioners had to face a government which seems determined to force us to choose between money and the ethics of our discipline. The Cardiff framework of the consultation served to highlight these issues. This may be another reason why it has stood the test of time and is used internationally by doctors in many different cultures.

I welcome Middleton's commentary but his concepts would have held more water if he had been comprehensive in his literature review, moved beyond minor modification of Balint's triad, and related his work to new issues for the 1990s.

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Audit projects for medical students

Sir,
It was interesting to read Neville and Knox's letter (October *Journal*, p.430) about audit projects for students at Dundee since we have recently introduced a similar scheme at Newcastle medical school.

For several years now students have been encouraged to carry out a small project during their family medicine attachment. Despite its being optional the majority of students chose to undertake a project, presenting their results at a seminar in the final week. A common complaint was the amount of time spent on the project, particularly as examination time approached, but the seminar itself was well received. Like Dundee, the topics chosen were many and varied, ranging from 'Characteristics of patients who send Christmas cards to GPs' to 'Audit of asthma care', though strictly speaking few of the projects were audits as such. Nevertheless questions about audit invariably arose in discussion, and the problems experienced by the students highlighted some of the problems of audit in 'real life': the generally poor state of record keeping; measuring only the measurable; opportunity costs and so on.

Publication of the white paper[1] concentrated our minds on the need for a more structured input and we have revamped the project accordingly. Unlike Dundee, we are asking students to carry out their audits on the same topic (which changes each session), though there is considerable room for individual interpretation. We thus hope to build up an archive of audit activity which will be of use to the participating tutors. As the authors state, 'compulsory audit of clinical activity will be the norm for doctors in the 1990s', and few would disagree that early exposure to the idea is important. The state of the art is such that departments of general practice are in the best position to provide the appropriate teaching and thereby to lead the way. It is a particularly exciting innovation since teacher and pupil alike will be feeling their way, adding a dynamic and challenging component to what is already a very different kind of clinical attachment.

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Core data for practice annual reports

Sir,
The paper by Howarth, Maitland and Duffus (November *Journal*, p.463) describes definitions used in a model annual report which were arrived at after discussion with interested parties in Scotland. The Chesterfield trainers workshop devoted some time to deriving definitions for their own use in practice reports and came up with almost identical definitions.

Because of the difficulties of making comparisons between different practices when similar definitions are not used, may I commend these particular definitions to all practices in the UK for their future practice reports and I would urge the College to distribute them widely.

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Continuing medical education

Sir,
I have been following the debate over the UK government's new postgraduate education plans with interest from this