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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?

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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.

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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.

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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

specificity of 89%. The likelihood ratio positive increased from 4.4 to 9.1 when considering a positive response to either screening question or the help question, which we consider more than a modest enhancement. The likelihood ratio of a patient who answered yes, wanting help today of having major depression was high (17.5). We agree with Mitchell and Coyne that ultra-short tests need second-stage assessment of those who screen positive. In the TQWHQ, the help question acts as a second-stage assessor, significantly reducing the number of false positives.

Allowing our GPs to see questionnaire data is criticised as contaminating our study. This is missing the point that GP diagnosis was one of the outcomes of the study. GPs had a sensitivity of 79% and a specificity of 94% when using the TQWHQ (measured against the CIDI), meaning that patients are unlikely to receive unnecessary treatment.

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Patient-centred diagnosis

Wilfred Treasure's review[1] of patient-centred diagnosis betrays one of the flaws in the concept of patient centredness. The presence or absence of pathology is a brute biomechanical fact. It is completely independent of any concepts of patient or doctor centredness.

Good communication skills, empathy and shared understanding may make the practice of medicine more patient centred, and may help us to diagnose more effectively, and to make the patient's journey more comfortable. It may also help us guide patients away from investigation when serious pathology is unlikely. However, all of medicine is rooted in pathology and no niceties of communication get us round this. Pathology is centred in the patient, (where else could it be?) and so the act of diagnosis is of necessity both patient centred and patient specific.

All medical knowledge is ultimately derived from patients, and is only of use when used to help patients. Yes some of it may be very technical or scientific, but this does not lessen its dependence on, and centring in, the patients we encounter. Practising medicine well, starting with accurate diagnosis, is actually the most patient-centred act any of us can make.

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Medical situation in Iraq

I am writing to you on behalf of the doctors and people of Iraq.

The situation is so dire I can only apologise to the people of Iraq on behalf of us all. I have seen several documentaries filmed secretly to 'get the message out'. I trust you will take the time to read the following, relating to yet another victim of violence.

Last night I witnessed another (Australia–Iraq produced) documentary on the medical situation in Baghdad, filmed (secretly) in one of the hospitals and the ambulances. To say it was shocking is an under-statement. I will mention one scenario only.

A 6-year-old boy, who was filmed having ADULT size 'chest tubes' (no child size tubes were available), forced through his ribs, to drain blood from his lungs, with NO anaesthetic (none was/is available).

I feel we all owe an apology to that little boy, and to his family, and to those who had to hold the little boy down and witness his torture, and an apology to the doctors of Iraq.

My work with Iraqi doctors, those remaining, who are overworked and over stressed and who have little tools or therapeutics, who are demoralised by the constant horror, who live in single rooms without hope, whose colleagues and loved ones have been killed in front of them, who often get no pay, cannot afford lunch, who often have no fresh water for themselves or patients, who often have no electricity, who cannot leave the country to further their education, who suffer the humiliation of rejection when they try to do such, has shown them to be some of the nicest and most cultured people in the world.

While I would hope the politicians of the world can sort out the war situation, with the best outcome for the Iraqi people as top priority, we in the medical profession surely must move to help our medical colleagues immediately. Iraqis have had decades of horror and deprivation and surely there is a limit as to how much more they can be expected to endure.

They need medical supplies and equipment. They also need the assistance, I suggest, of an influx of medical professionals, to help fill some of the more urgent gaps and provide some relief. I know the situation is dangerous, and our honourable Iraqi colleagues are the first to warn people away from coming, because of that danger.

We cannot change the past, but we can change the future for the Iraqi people and the doctors trying valiantly to care for them. I believe, if we all took a stand maybe we could turn it around for them. They are worth it.

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