determine the cause of limited mobility: osteoarthritis of hips or knees, chiropody problems, etc. In contrast, disease oriented or problem oriented screening would require a long checklist of problems to be gone through—a much more time consuming method. It is also inefficient as it will almost certainly create a long list of problems—that is, apparent unmet needs—when in reality many of these problems are of minimal functional importance. In terms of chiropody it is less important to determine the number of older people with corns and bunions than those who are experiencing difficulties with footwear or walking because of chiropody problems.

Criteria for functional assessment of patients aged over 75

Mobility	Senses	Continence	General function
Gait	Problems with conversation or television	Frequency	Cooking
Negotiating stairs	Ear wax	Dysuria	Diet
Rising from chair	Use of hearing aid	Stress incontinence	Shopping
Transferring	Able to read newspapers	Prostatic symptoms	Dressing
Balance	Recognises faces across the room	Pattern of bowel function	Bathing
Use of aids	State of glasses	Recent changes	Toileting
		Laxative use	
		Faecal staining	

The lack of available treatment for some of the problems likely to be detected—for example, the socioeconomic deprivation of many older people—fails to meet one of the criteria to be satisfied when introducing screening.[7] It may not be too idealistic, however, to believe that the systematic collection of this type of information could produce a powerful statement on the unmet medical and social needs of older people in Britain and lead to a more appropriate distribution of available resources. To a large extent this will depend on the impact of other current legislative changes relating to community care.

A review of medication is a particularly relevant feature of good practice in the care of older people and should consider the need for continued treatment, the presence of side effects and interactions, the costs of treatment, and the use of non-prescription drugs. It also provides the opportunity to assess compliance and the need to provide help in understanding and following drug regimens.

The prevalence of depression and dementia among older people justifies the inclusion of assessment of mental state in screening. Depression is common, frequently missed, and can often be treated effectively. For the detection of dementia several short mental state questionnaires are in common use, and the type of questions included are shown in the box. Three or more incorrect answers suggest intellectual deterioration, and the number of errors indicates the severity. Williamson's functional case finding protocol provides a more detailed framework for the sociomedical screening of older people.[8]

It needs to be emphasised that brief functional and mental assessments cannot have complete validity, and therefore false positive and false negative results are to be expected. Indeed, even more detailed assessments do not have 100% specificity and sensitivity.

Who should screen?

The new contract does not require screening to be done by the doctor, but as already discussed there is an important potential for opportunistic screening. Health visitors and practice nurses can also carry out screening during routine contacts. In larger practices and particularly those with above average numbers of older people it may be necessary to involve existing members of the team or perhaps to engage additional practice nurse time to ensure that all eligible and willing patients are screened. The capitation fee for the 75 and over age group has been increased by 120%, and this should go some way to subsidising any required increase in staff resources.

Short questionnaire to determine mental state

1 Today's date
2 Day of week
3 Age
4 Address
5 Year
6 Date of birth
7 Year of first world war
8 Name of monarch or prime minister
9 Count backwards from 20 to one

Conclusion

The manner in which these and other contract changes were introduced has led to an unfortunate loss of good will on the part of many family doctors. In particular, the changes seem to underestimate the commitment of many British general practitioners to good care of older people, including preventive care. Moreover, most older people are reasonably healthy, well, and content, so that imposing universal domiciliary screening on an annual basis seems to be a wasteful use of limited resources and to be inconsistent with the principle of targeting support to those with greatest needs, which is fundamental to the government's other legislation on community care. Whatever criticisms can be directed at the government for its insistence on annual domiciliary screening of all people aged over 75, it has to be said that the areas covered by the contract provide a reasonable framework for a sociomedical profile of older patients and the elderly population.

It is important that general practitioners support an anticipatory dimension to the care of older people, but at the same time those who administer general practice need to recognise that variation in general practice is not only a reality but can also be a strength. The emerging local dialogue between family practitioner committees, health boards, and general practitioners may mean that the contract changes will be introduced with more pragmatism than rigidity and that monitoring of the contract's operation and impact can be used to make the changes that experience and evidence dictate.

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Correction

Decontamination of instruments and control of cross infection in general practice

A printers' error occurred in this practice observed article by Mr D R Morgan and others (26 May, p 1379). In the second paragraph of the discussion a previous report had indicated that only 8% of practices had autoclaves and not 80% as published.