Screening for depression in secondary care

Sir,

There is evidence of the lack of benefit of screening questionnaires for depression in primary care (Croudace et al, 2003), but there are no published studies on the usefulness of screening questionnaires for psychiatric illness in secondary care. All new referrals to an inner city psychiatric clinic were asked to complete the General Health Questionnaire (GHQ) before being seen, this being a well-validated epidemiological screening instrument. The 30-item GHQ was used which distinguishes between normal subjects, psychiatric outpatients and severely ill psychiatric inpatients (Goldberg et al, 1976).

Over 23 years 345 patients were asked to complete the GHQ-30, which provided complete data for 206 patients. All patients were assessed by the professor of psychiatry without knowledge of their GHQ score. They were placed in broad diagnostic groups, which included learning disability, organic brain disease, personality disorder including substance misuse, psychosomatic, functional psychosis, depression, other neurosis or no psychiatric diagnosis.

There were no differences in GHQ score between men and women, and scores on the GHQ were not able to distinguish between different diagnoses. Different cut-offs made little difference to the predictive value of the screening test, probably because of the high level of psychiatric morbidity in this population.

The GHQ-30 was of limited use in discriminating caseness in a psychiatric outpatient clinic. This finding highlights the importance of clearly defining the population, and also how reminds us that the usefulness of screening tests varies with the population studied.

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Training in breast reconstruction

Sir,

Dick Rainsbury's timely editorial (vol 64(12), 2003, p. 700) highlights the tension between the vision of high quality and holistic breast cancer care, and the pressures to provide treatment. Autogenous tissue reconstruction demands combined oncological and reconstructive skills, and the opportunity to provide patients with surgeons who can integrate tissue ablation and tissue restoration is extremely attractive.

Perhaps 10% of women who could benefit from reconstruction are able to proceed with it. Provision of an immediate breast reconstruction service demands a high level of resourcing so that treatment targets can be met while adequate counselling and support can be given to patients who have to balance the choice of simple *vs* complex reconstructive options, the possibility of complications and cope with continuing treatment of the breast cancer.

The NHS is committed in principle to delivering the highest quality of care and offering patients choice. New initiatives such as the Oncoplastic Breast Training Programmes need to develop across specialty borders, coping also with pressures resulting from radical alteration in surgical training programmes and the limitation of doctors' hours.

Health-care delivery needs to cope with ever-increasing patient expectations and with the upward spiral of the need to improve outcomes. This new training scheme is a practical means of focusing surgical skill and improving care. It is to be hoped that the beanstalk which may grow from this small seed will not be axed by antagonism between specialties, or worse still, by political apathy once the imperative for this project to succeed has passed.

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Sir,

The emergence of breast surgery as a specialty has been an exhilarating and challenging experience. Breast surgery is at an evolutionary crossroads: many factors will influence the outcome but developments in oncoplastic breast surgery and shortened surgical training combined with shifting configuration and delivery of general surgical services are likely to catapult breast surgery into its next phase.

Breast surgery accounts for 25–30% of general surgery workload but has not attracted trainees. Trainees have been discouraged by the heavy and emotionally demanding clinic workload combined with the perceived lack of technical challenges.

However, attitudes are changing. Breast surgery is attracting 'holistic' surgeons who are drawn to the high standards of care and the intellectual rigors of multidisciplinary working as well as the technical challenges. The success of oncoplastic training fellowships will prove to have been instrumental in effecting this transformation.

Trainees, from both plastic surgery and general surgery, are redefining traditional roles and professional boundaries. General surgeons with an interest in breast may be transitional providers. Competing demands between specialization and general surgery mean some newly appointed oncoplastic trained breast surgeons no longer offer a general surgical service. If the devolution of breast from general continues, the ramifications for future service provision and training are far-reaching. We need to consider these implications and be ready to respond to future trainees' needs.

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