haemodialysis equipment,¹⁷ the accumulation of a uraemic metabolite,¹⁸ and increased production of so called "renotropic factors."¹⁹⁻²¹ Interestingly, acquired cystic disease may stabilise or regress after renal transplantation,^{13 22} and Thomson *et al* (p 1209) suggest that the condition may thus be an added indication for transplantation.

Ishikawa reviewed 1103 patients reported in a mixture of necropsy and prospective studies and found that about half had acquired cystic disease of the kidney.¹⁶ In patients dialysed for over three years the prevalence may be nearly 80%. Most patients have no symptoms, although painless haematuria occurs. Retroperitoneal haemorrhage may present with acute loin or abdominal pain and necessitate nephrectomy or arterial embolisation. The major importance of acquired cystic disease of the kidney is, however, its association with solid tumours²³: Grantham and Levine found that 16% of patients with the condition had tumours.²⁴ Many were small and considered benign, but others were malignant with renal vein extension or metastases. The incidence of malignant change is difficult to define but may be up to 5% in patients with tumours or about 1% in patients with acquired cystic disease of the kidney.^{16 24} Whether there is a causative link between acquired cystic disease of the kidney and such tumours is not established.

How then should the condition be managed? More evidence is needed from long term studies of the clinical course of acquired cystic disease of the kidney before definite guidelines can be given. For now, however, annual ultrasound examination is recommended as a screening test,²⁵ although computed tomography is better for showing changes—particularly the development of tumours—in shrunken kidneys.¹³ Ideally those patients shown on ultrasound examination to have acquired cystic disease of the kidney would be followed up by annual computed tomography. Nephrectomy is indicated if there is haematuria and a tumour, or if a tumour is enlarging. Even small tumours may metastasise,²⁶ but lesions less than 3 cm in diameter can probably be treated conservatively with careful observation.²⁴

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Easeful death

Last year 6000-10 000 Dutch patients are estimated to have persuaded their doctors to help them in their wish to die sooner rather than later. A survey of colleagues by a general practitioner in one region of the Netherlands found that nearly 80% had direct experience of euthanasia. Many doctors have deliberately courted prosecution by writing on the death certificate that death was not due to natural causes. Some have gone as far as to state "active euthanasia" as the cause of death. Almost all of the dozen or so doctors prosecuted in the past two years have been acquitted.

Pressure is growing within the Dutch parliament and from the general public for a revision of the penal code to exempt doctors from prosecution when euthanasia is carried out at the express wish of the patient or when death is accelerated in a terminally ill patient by the failure to treat a secondary illness (such as pneumonia) or by sedatives given to treat pain, or when further treatment has become pointless.

Despite widespread support for these proposals, which were agreed by 13 of a 15 member state commission, no new statute is likely to be passed by the present government because the Christian Democrats, the party with the largest representation in the coalition government, have religious objections. Their partners, the Liberals, favour a relaxation but are reluctant to precipitate a premature election by joining with the opposition Socialists to force through such legislation. This means that some Dutch doctors will remain in jeopardy for at least four years, until after the next general election; and elderly patients in long stay hospitals and parents of malformed babies will continue to be alarmed about what they see as an uncontrolled movement towards including intentional killing in the range of treatment options.

Speaking at a recent conference on medical ethics at the Royal College of Physicians in London, Professor the Reverend Gordon Dunstan said that euthanasia destroyed good medicine. Compassion and the patient's consent are not sufficient to justify professionally assisted homicide. The doctor should, however, be free to change to a management "appropriate to the patient's interest in dying" when a terminally ill patient believes that it is no longer in his interest to live. Such a change is not withdrawal of treatment.

The scale of euthanasia can only be guessed at, and little is known about the patient's motivation. Dr J-O Ottosson, a psychiatrist, showed that "rational suicide" (committed with determination in response to a cause such as an incurable disease or political oppression) is rare: none of 271 recent suicides in Swedish men belonged to this category. So how can a doctor be certain that a patient's wish to die is real and not a symptom of depression or a cry for contact and empathy? In well publicised cases^{1 2} in which relatives have

aided the suicide of an incurably ill person the patients have had a strong personality and sense of autonomy—and so may not be typical.

Dr Ottosson warned that handicapped people may feel troublesome and may express the wish to die because they feel that relatives should not continue to be inconvenienced. If there was a general loosening of restraints an attitude of callousness and hopelessness could spread, nursing care would suffer, and “omnipotent colleagues” might allow economic considerations or the interests of relatives to become overriding.

An examination of euthanasia in the United Kingdom is overdue. It is 15 years since the BMA published its last inquiry.³ Unlike Dutch doctors, British doctors have not forced this dilemma into the open—there has been only one prosecution of a British doctor since the last report. In a survey in 1985 sponsored by the British Voluntary Euthanasia Society almost three quarters of a sample of the general public agreed that “the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them.” Only 15% of doctors agreed. The 1986 annual representative meeting of the British Medical Association urged the association to reconsider its policy that euthanasia “cannot be accepted by the medical profession.”²

To what extent will the newly formed BMA ethical committee on euthanasia, chaired by Sir Henry Yellowlees, be able to balance the seemingly conflicting demands of respect for the autonomy of the individual and maintenance of the corporate sense that it is morally wrong to kill?

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Use of the general health questionnaire in clinical work

Questionnaires have been used many times to detect psychiatric illness in general medical settings, with most studies emphasising that a substantial proportion of people shown to have a psychiatric illness using a research interview had not always been thought to be “cases” by the clinicians who were providing care.¹⁻³

The temptation for clinicians is to use screening questionnaires in too simplistic a way, assuming that those with scores above some arbitrary threshold are psychiatric cases and those below are not. Unfortunately this cannot be done, nor can one assume that the proportion of people with high scores is the same as the probable prevalence of disorder in a particular population. Those who wish to use the general health questionnaire to detect the hidden psychiatric morbidity of medical practice⁴ face rather different problems from those who wish to use the questionnaire for research.

The positive predictive value of a test is the probability that those with scores above the threshold will be thought to be cases. This value will be around 50% for those who score at the threshold, but the predictive value rises with increasing

score. Furthermore, the threshold score will be affected by the degree of physical illness of the particular patients—for example, with the general health questionnaire-28 the best threshold is 4/5 with patients attending general practitioners,⁵ but it must be raised to 11/12 for inpatients on neurological wards.⁶ Even if the threshold is known for the particular patients being studied, many “cases” will score below the threshold, just as many of those with scores above it will not be thought to have any important psychiatric illness.

When a patient is found to have a high score the most natural response by the clinician is to look at the questionnaire with the patient and ask additional probe questions suggested by particular symptoms. Most of the false positive results will be found in those patients experiencing transient disorders which are likely to remit spontaneously, but they will not have been harmed by having discussed their symptoms with their doctor. If there seem to be more false positives than true positives the threshold for discussing symptoms with the patient may be raised—but it may seem more sensible to examine the completed general health questionnaire in each patient and to discuss any symptoms which cannot be explained by the known physical pathology. For example, a patient with bronchopneumonia may get a high score by endorsing several symptoms dealing with physical malaise and social dysfunction (the A and C scales of the general health questionnaire-28): if, however, they score highly on the depression subscale (D scale) as well, these symptoms should be discussed to establish their severity and duration. The disorders uncovered by the general health questionnaire are similar in type to those which the clinician already knows about: most patients will not require specialist referral, but many will require chemotherapy or social intervention—and all are likely to benefit from discussion.

The researcher, by contrast, typically wishes to predict the level of psychiatric illness in a particular population from a knowledge of the proportion with scores above some arbitrary threshold.⁷ He does not share the clinician's interest in the positive predictive value of the test, since he recognises that this is not an immutable characteristic of a particular screening test but is in fact highly dependent on the prevalence of disorder in the population being considered. However, he can predict prevalence provided that estimates of sensitivity and specificity are available for a comparable population.⁸

The estimate of prevalence will depend on the criterion for “caseness” used in the particular validity study cited: generally speaking, the most conservative estimate will be that using the PSE-ID-Catego method⁹ and the most inclusive that using the clinical interview schedule,¹⁰ with the newer DSM-III-R method being intermediate.¹¹ The various methods give different results because each uses somewhat different criteria for caseness, especially with regard to the length of time that symptoms must be present in order for the patient to be counted as a case. Those wishing to carry out their own validity study need to be aware of some pitfalls for the unwary.

If the population for study has a high prevalence (over 40%) of psychiatric disorder then the simplest design of a validity study is to interview a random sample of perhaps 60 patients. Sensitivity and specificity are then calculated for each possible threshold of the general health questionnaire, and the resultant set of values drawn as an “ROC curve.”¹²⁻¹⁴ The concept of a “relative operating characteristic” (ROC) is derived from signal detection theory and is being increasingly used in the assessment of screening procedures in medicine. The area under the ROC curve can be used to compare the