today, to reduce costs), are we ignoring one of the traditionally powerful forces in healing, ie, the art of medicine? Dr. Berg might find it strange that in this scientific era, one would support such nonsense as a patient's faith and belief in his or her physician having something to do with the healing process (certainly impossible to quantify).

Dr. Berg's comment "Without exception these experiences show that the layer of scientific evidence upon which much of medical care is based is very thin indeed" seems to me to be based more on his clinical experience with four panels than a true, evidence-based conclusion. It is certainly a poorly substantiated generalization appearing to be based more on anger and frustration than documentation of evidence.

I would not disagree that we need to pursue rational justification for the things we do in medicine. I think we must also guard against the elitist (and usually academic) view that if a practice or a method or treatment can't be proved with a scientifically designed study and if we can't get the important data into our computers to manipulate, then somehow that method or practice is less worthy because that attitude itself is unscientific and cultist. It is important for all of us to understand the evidence-based systems, but we must include in them those much more difficult studies that are much less amenable to statistical manipulation, ie, studies that have to do with the effects of the art of medicine. I believe we leave the art of medicine out of our equations at our patients' and our own peril.

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To the Editor: I read with pleasure the recent special communication on clinical practice guideline panels by Dr. Berg (Berg AO: Clinical practice guideline panels: personal experience. J Am Board Fam Pract 1996; 9:366-70). His discussions, cautions, and suggestions underscore the degree to which medical practice has been guided, albeit somewhat blindly, by scientific doctrine.

One area Dr. Berg did not specifically address, which I believe is relevant to clinical practice guidelines, is the depiction of knowledge in a graphic-based format. Several of the panels with which Dr. Berg has been involved have created small algorithmic approaches to clinical decision-making and practice guidelines. Graphically linking decisions with particular outcomes greatly enhances and clarifies many of the issues within a particular area. Having been involved with graphic depictions, I see their continued emergence as valuable and expect that they will be included more often in future practice guidelines.

Another area is the incorporation of computers into medicine. I expect computers and expert systems to be increasingly used in clinical practice guidelines and look forward to future panels that utilize this form of communication.

Dr. Berg's article, personal experience, and example not only stand as a tremendous source of strength for the family physician who attempts to integrate multiple systems and family concepts into decision making but also underscore the complexity involved in even the most apparently simple clinical issues.

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Mental Health Patient Profile

To the Editor: The study by Mazonson, et al,[1] who screened waiting patients for anxiety, was well supported until the concluding paragraph. The authors then state, "Our results show that patient self-reported information on anxiety and psychological health, collected in a manner that places minimal burden on primary care physicians and their staffs, can lead to heightened physician awareness." The authors screened 7914 patients to find 618 patients meeting the study criteria for anxiety. Thirty-four patients in the intervention group were referred for a mental health evaluation, and 45 were placed on psychotropic medications. By comparison, 7 patients were referred for evaluation and 37 patients were prescribed medications in the control group. The additional 35 patients found through this intervention represent 0.5 percent of the 7914 patients initially screened. The authors fail to support their conclusion that screening represented a minimal burden to the other 99.5 percent.

Greater Valley Medical Group is also a mixed-model health maintenance organization serving 60,000 patients in Los Angeles, a practice similar to the study practice. Our new patients spend 30 to 45 minutes completing our front office forms and eligibility checks. Patients already enrolled often spend a similar amount of time waiting when they change insurance carriers or jobs. This wait not only engenders complaints but creates a burden for our patients and our staff. For this reason, we recently reviewed and rejected a request to add additional screening questions for sexually transmitted diseases, risk factors for infection with human immunodeficiency virus, and exercise and diet to our initial new patient questionnaire. We considered adding these questions because such screening is recommended by the US Preventive Services Task Force[2] and is included by health plans in their office record audits. In contrast, the USPSTF recommends against screening for depression. According to the Clinician's Handbook of Preventive Services, "The performance of routine screening tests for depression in asymptomatic individuals is not recommended.[2]" Anxiety screening is not even mentioned in this reference.

Screening for depressive illness would create more than a minimal burden on a busy office. It would have been helpful to measure the patients' and staff's response to the screening procedure. Would the staff have been willing to continue with the extra forms and