of depression diagnosed clinically as either "neurotic depression" or "psychotic depression"; half the cases were diagnosed by one clinician and half by another. Not only were the proportions diagnosed "neurotic" and "psychotic" by the two clinicians significantly different ($P<0.01$), but the clinical labels bore no relationship to questionary responses. The pattern of response in cases we diagnosed as "psychotic depression" was also markedly different to that found in cases called "psychotic depression" at another hospital.[3] Both clinicians had over four years' experience in psychiatry, and these results emphasize, I believe, the difficulties and uncertainties which do in fact surround the classification of depression. The reasons for these difficulties are complex,[4] but it is surely better to recognize that this is so than to assume, as in your leading article, that the problem is simple and easily solved.—I am, etc.,

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Haemodialysis Disequilibrium

SIR,—Dr. S. M. Rosen, Mr. K. O'Connor, and Dr. S. Sheldon (12 September, p. 672) confirm that during haemodialysis there is a delay in the removal of urea from the cerebrospinal fluid, as compared with plasma, resulting in an abnormal urea gradient between C.S.F. and plasma. This in turn results in "transfer of water from plasma into C.S.F. with a subsequent rise in intracranial pressure and consequent symptoms." They recommend "that haemodialysis be performed at low levels of biochemical disturbance, for short periods of time, and at frequent intervals."

This should reduce the incidence of complications due to an increase in intracranial pressure, but unfortunately places some restrictions on the use of this valuable treatment. Could not the same result be achieved by lumbar puncture and reduction of C.S.F. pressure? This could be performed prophylactically when the initial plasma-urea concentration is high, or on the appearance of complications due to a rising intracranial pressure, and repeated as necessary.—I am, etc.,

London W.11. M. BLOCH.

Practice Expenses

SIR,—The same mixture as before! Your leading article (22 August, p. 463) on the Minister of Health's proposals on practice expenses produces a combined feeling of anger, dismay, and disgust. How callous to say, "The money to be refunded will not be extra money. It will be money diverted from the central pool, and the amount available for distribution in capitation and other fees will therefore be less by the amount paid out under the scheme." Robbing Peter to pay Paul! The recent revolt on the so-called 14% increase has taught the G.M.S. Committee *nothing*. I call on my fellow general practitioners to reject these proposals and to insist that the G.M.S. Committee should resign.—I am, etc..

Troon, Ayrshire. IRWIN KRAUTHAMER.

SIR,—While on holiday during August, cut off from professional journals and my colleagues, I had the quite definite impression from statements made by the Minister of Health and by the Chairman of the General Medical Services Committee, and published in the national press, that the new arrangements for direct payment for ancillary help in general practice involved new money and would not come out of the Pool. It is only on my return from my holiday that I find out from my partner and from the *British Medical Journal* that this money will come out of the Pool and involves no fresh money whatsoever.

This is just one further example of dishonest ambiguity on the part of the Minister and of complete ineptitude in the field of public relations by our elected representatives. How much longer are we, as a profession, going to suffer until the Association employs an efficient public relations department?—I am, etc.,

London W.13. JOHN H. SWAN.

*** Statement by Minister of Health (*Supplement*, p. 135). Leader at p. 769.—ED., *B.M.J.*

Problems of Practice To-day

SIR,—Should we not get clearer still in this correspondence the basic problems of medical practice here to-day, while our theorists make their contradictions and others their particular and general nostrums?

The most disturbing thing nowadays to my middle-aged contemporaries in general practice both before and after the last war is the decreasing ability of our adult patients to think for themselves, know themselves, or learn to act for themselves. Several factors in our more mechanized and scientific civilization no doubt have contributed to this decline in personal responsibility, but I find quite pathetic the degree of cross-examination and cajolery needed to treat effectively the descendants of our erstwhile sensible and once intelligent fellow-countrymen.

As distinct from Sir Robert Platt's dictum as a consultant, recently quoted (Dr. B. C. S. Slater, 29 August, p. 574), that no patient seen by him was without a medical problem, the plain truth is that to-day in general practice many, too many, of the wants of our patients are not really medical problems, nor even psychological, but arise from undigested experiences and unsatisfied feelings that should not need a doctor to explain still less treat.

Now, to the Gillie school: this situation should be solved by the bigger conception of the general practitioner as head of a medico-social welfare team, but the difficulty, frankly, is that the patient is too incapable of responsible action, let alone recognition, of the realities of his difficulties, conditioned as he is to expect a quick, easy, free cure. It is surely this need for him to think once, if not twice, before a visit or call on his doctor that opponents of the present free-for-all service are trying to encourage, with the caveat fulfilled that the neediest would not then be the hindmost, since they would not be so deterred by a token fee in an item-of-service insured scheme as encouraged by the less full waiting-room or earlier appointment and the assurance that all the time and attention necessary is being given them. On the other hand, the fashionable alternative of the bureaucratic administration of a group practice or health centre could be a bigger barrier to good general practice than the alleged financial one, which should in addition ensure the full service required, while the former may only lead to a false sense of achievement.

But as it is to-day, even after careful examination of the patient, with intimate knowledge of him and his family, his preconceptions and ignorance only too often necessitate futile investigations by hospital specialists, and turn him into just another scientific case with lessened ability to realize and deal with his troubles. It is this reduction, it seems to me, of the specialists to scientific case-collectors that has diminished their former ability to render a valuable contribution in consultation and it has certainly aggravated the revolt of general practitioners against the specialists' attempts to dominate the whole field of medicine, when they can no longer exercise the comprehension, even of general principles, of their consultant predecessors in admittedly smaller fields of knowledge.

But there is, as I see it, another great danger looming up that, with the proposed co-operation of social welfare agents, a patient's troubles are liable to be turned into a medico-social problem case. For, in spite of the repeated assurance of the general practitioners being the king-pin, the Gillie set-up can only work through the distinctive function of each different social worker who will continue to maintain the importance of their own contribution and so render a complete solution rarely attainable, despite Penelope Hall's idealistic view of social work (August 22, p. 575). This was my recent experience of our local problem families' case work, and I fail to see how the proper direction of the specialized social worker, even under the 1963 Act, could be thought to be safeguarded.

Is it then really our professional duty to our patients to allow them to be subjected to this surveillance in their intimate lives? Such a situation could surely become more totalitarian than that of any political regime of any complexion, and render them disastrously vulnerable to the most insidious of influences, besides undermining their own morale.—I am, etc.,

Debenham, Norfolk. CHARLES A. HUTT.

Charges for Patients

SIR,—The image of the medical profession in the eyes of the public or of lay persons concerned with the administration or control of medical affairs must surely be influenced by the letters appearing in the *B.M.J.* In view of this I am sometimes amazed to read some of the letters printed. Of course, the journal must allow doctors to express themselves freely, but it is necessary for individuals to exercise common sense and restraint in their letters.