LETTERS

Fundholding practices get preference

EDITOR,—The new management style of the NHS is having a corrupting influence. My local hospital, in Brent, has stopped admitting from the waiting list any orthopaedic patient who lives in its borough. Each of these people has previously attended the outpatient department, consulted one of the hospital's surgeons, and been promised proper professional care. The hospital's managers have now persuaded the surgeons to see and operate on new patients from fundholding practices in Hertfordshire to the exclusion of the local residents in Brent. The hospital seems to have informed neither the patients whose treatment has been postponed nor their doctors.

There can be little doubt that the duty of care for every doctor begins when a patient is first accepted for treatment. Thereafter the doctor is duty bound to look after that patient properly. If geographical restrictions must be imposed surely they should be applied before that first consultation rather than after the doctor has agreed to treat the patient. Once patients have been offered professional care and have accepted it all doctors (including surgeons) have an ethical duty to treat them with equal consideration. It is time that doctors refused to collude with the hospital managers in unethical behaviour and the neglect of their patients.

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Recognising and managing depression in general practice

EDITOR,—Though we welcome the consensus statement on recognising and managing depression in general practice,[1] we are concerned that it does not mention the special problems of identifying and treating such depression in elderly people.

Depression affects as many as 30% of elderly people attending their general practitioner but is often missed or not treated.[2,3] Depression in older people is difficult to detect because of the lack of typical features such as guilt and the frequent presence of somatic symptoms.[4] Use of simple screening instruments such as the geriatric depression scale[5] or the self-CARE D[6] can achieve high detection rates in a primary care setting.[6,7] Depression in old age carries a relatively poor prognosis[8] and a particularly high risk of suicide.[9] Treatment is problematic because of increased vulnerability to side effects, but if given appropriately it not only may be associated with similar or better response rates than those in younger patients but may also improve prognosis.[10]

We urge the Royal College of Psychiatrists and the Royal College of General Practitioners to set up a separate consensus exercise aimed at addressing the problems of defeating depression in old age.

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1 Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992;**305**:1198-202. (14 November.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

2 Macdonald AJD. Do general practitioners "miss" depression in elderly patients? *BMJ* 1986;**292**:1365-7.
3 Iliffe S, Haines A, Gallivan S, Booroff A, Goldenberg E, Morgan P. Assessment of elderly people in general practice. 1. Social circumstances and mental state. *Br J Gen Pract* 1991;**41**:9-12.
4 Brown RP, Sweeney J, Loutsch E, Kocsis J, Frances A. Involutional melancholia revisited. *Am J Psychiatry* 1984;**141**:24-8.
5 Yesavage JA, Brink TL, Rose TL, Lum O. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res* 1983;**17**:37-49.
6 Bird AS, Macdonald AJD, Mann AH, Philpot MP. Preliminary experience with the Self-CARE D. *International Journal of Geriatric Psychiatry* 1987;**2**:31-8.
7 Evans S, Katona CLE. Depressive symptoms in elderly primary care attenders. *Dementia* (in press).
8 Katona CLE. The prognosis of depression in old age. In: Arie THD, ed. *Recent advances in psychogeriatrics II*. Edinburgh: Churchill Livingstone, 1992.
9 Sendbuehler JM, Goldstein S. Attempted suicide among the aged. *J Am Geriatr Soc* 1977;**25**:245-8.
10 Baldwin D. The outcome of depression in old age. *International Journal of Geriatric Psychiatry* 1991;**6**:395-400.

EDITOR,—The consensus statement on the recognition and management of depression in general practice makes little reference to the role of psychotherapeutic principles.[1] An interpersonal or psychodynamic psychotherapeutic approach emphasises the importance of listening to the patient, which can be therapeutic in itself; but it also requires active exploration of the patient's subjective experience, linking the depressed affect to salient (external or internal psychic) events, especially those entailing loss and interactions with others. The patient's establishment of a personal meaning to the affective experience can be immensely relieving, permitting spontaneous correction of negative ways of thinking about self and the world.

The consensus statement emphasises specific psychological treatments, particularly cognitive and behavioural therapies, at the expense of a more fundamental psychotherapeutic strategy. Forms of psychotherapy are mentioned only in the context of general psychosocial management, as if they are not psychological treatments in their own right; and despite the long tradition of psychotherapeutically informed general practice[2] no indication is given that psychotherapeutic techniques may be used successfully by general practitioners or other primary care staff.

This statement could result in general practitioners relinquishing established empathic listening skills in favour of active technical interventions. While advice, social intervention, and behavioural and cognitive methods have an undoubted place in the primary care management of depression, it would be unfortunate (and counter productive to the aims of the "defeating depression" campaign) if general practitioners became psychological technocrats. As a result of this statement it would be all too easy for general practioners to believe that they should be doing something with or to their depressed patients. Paradoxically, this may diminish the very skills (especially unhurried listening) that are acknowledged to be essential for the enhanced recognition of depression by general practitioners.

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1 Paykel ES, Priest RG. Recognition and management of depression in general practice consensus statement. *BMJ* 1992;**305**:1198-202. (14 November.)
2 Balint M. *The doctor, his patient and the illness*. London: Pitman Medical, 1957.

EDITOR,—General practice provides an opportunity to practise family medicine in relation to all age groups. This perspective must not be missed.

What do general practitioners need to know about the alternative presentations of depression in childhood? What do they need to know about the consequences of parental depression on child development? How does this get integrated in an educative approach? How do you treat the family to prevent concomitantly disturbed children precipitating relapse in a treated adult?

The consensus statement on depression[1] needs to be regarded as an important start, but the developmental and family perspectives are not mentioned.

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1 Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992;**305**:1198-202. (14 November.)

Life insurance and HIV antibody testing

EDITOR,—Simon Barton and Peter Roth's editorial on life insurance and HIV testing leaves me in no doubt that despite the best efforts of interested parties the insurance companies are refusing to stop discriminating against people who have bothered to have an HIV test, albeit with a negative result.[1]

Last year I lobbied my local MP to exert pressure through her parliamentary select committee; since that meeting I now insert this typewritten statement over any question that refers to HIV: "It is not in the long term interest of the health of the nation to penalise people who have bothered to establish their HIV status. As long as insurance companies penalise people who have had an HIV test and are negative, I remain unable to cooperate with them in answering this question."

It is general practitioners who fill in insurance forms, and they seem to be the only people who can affect the behaviour of the insurance companies. Perhaps if all general practitioners adopted a stance on this point the insurance companies would be forced to cooperate.

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1 Barton S, Roth P. Life insurance and HIV antibody testing. *BMJ* 1992;**305**:902-3 (17 October.)

EDITOR,—Paul Gibbons's account of being asked to undergo an HIV antibody test to obtain life