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.

OLIVER SAMUEL

Pinner,
Middlesex HA5 3EW

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 scale⁵ or the self-CARE D⁶ can achieve high detection rates in a primary care setting.^{6,7} Depression in old age carries a relatively poor prognosis⁸ 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.

CLE KATONA
G LIVINGSTON
S ILLIFFE

University College London,
London

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 Illiffe 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. Involuntal 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.

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8 Katona CLE. The prognosis of depression in old age. In: Arie THD, ed. *Recent advances in psychogeriatrics II*. Edinburgh: Churchill Livingstone, 1992.

9 Sendbuchler 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 practice² 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 practitioners 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.

MICHAEL HOBBS

Department of Psychotherapy,
Warneford Hospital,
Oxford OX3 7JX

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 depression¹ needs to be regarded as an important start, but the developmental and family perspectives are not mentioned.

SIMON R WILKINSON

Oslo Kommune Ullevål Sykehus,
0407 Oslo,
Norway

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 type-written 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.

JL OGLE

Honicknowle,
Plymouth PL5 2LX

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

insurance is relevant to other health care workers in this situation.¹ I was interested to read that a few companies would treat him as a special case if he subsequently acquired HIV infection in the course of his duties. The onus of proving causation would, however, be on him.

The NHS injury benefit scheme would also compensate infected workers for loss of earning ability.² Again, however, it is stated that "work related infection would have to be established." To do this "a record of a specific injury and evidence of seroconversion are not regarded as essential but would be helpful in proving causation."

Astbury and Baxter found that only 18% of such injuries were reported on an accident form and 5% were notified to the occupational health service.³ Thus in most cases the health care worker is unlikely to have either an official record of the injury or evidence of seroconversion after exposure. Moreover, it has been pointed out that HIV infection acquired occupationally is not a pre-scribed disease, unlike hepatitis B,⁴ which seems to be an anomalous state of affairs.

What advice, then, should we give injured health care workers? Certainly, they should report the injury on an accident form, and to the occupational health department. HIV antibody testing would be considered only after careful counselling. I have argued that testing in these circumstances should not affect the workers' ability to obtain life insurance cover at normal rates.⁵ A record of the injury and documentation of subsequent seroconversion if it occurs would allow the workers to obtain injury benefits more easily and give them a better case should they wish to obtain compensation from their employer through a civil claim.

JACQUES TAMIN

Clayton Aniline,
PO Box 2,
Manchester M11 4AP

- 1 Gibbons P. Life insurance and HIV antibody testing. *BMJ* 1992;305:1093. (31 October.)
- 2 Department of Health. *AIDS—HIV infected health care workers. Occupational guidance for health care workers, their physicians and employers. Recommendations of the expert advisory group on AIDS.* London: DoH, 1991.
- 3 Astbury C, Baxter P. Infection risks in hospital staff from blood: hazardous injury rates and acceptance of hepatitis B immunisation. *J Soc Occup Med* 1990;40:92-3.
- 4 Williams S, Cockcroft A. Policies for HIV and hepatitis B infected health care workers. *Occupational Health Review* 1992;36:12-4.
- 5 Tamin J. HIV testing and life insurance. *Occup Med* 1992;42:119.

EDITOR,—Simon Barton and Peter Roth's editorial on life insurance and HIV antibody testing¹ highlights a problem that has adversely affected the acceptance of screening for HIV infection. Yet should we be so surprised by the requirements of the insurers, who, like the reformed NHS, are running businesses not charitable societies?

Current practice is to screen patients only with their informed consent after pretest counselling. Part of this procedure is an attempt to quantify the patient's risk on the basis of reported behaviour. Few people attending a genitourinary medicine clinic are likely to be at no risk, but some might believe that their risk is too low to justify future problems with insurance or mortgage.

Perhaps we should try to understand the insurance companies' point of view. At present a positive test result signifies death within a decade for most patients, but a survey in Riverside Health Authority showed that more than a quarter of patients would not divulge their HIV status to an insurance company.² Testing by consent leads to the conclusion that acceptance implies a degree of increased risk. In these circumstances is a request for further information not to be expected?

From the public health point of view, the situation is even less satisfactory. What incentive is there for a person at high risk to be tested? For a person, ignorance of infection may be preferable to the modest extension of lifespan afforded by early

intervention; for the community, however, this view begs the question of transmission of HIV by those unaware of their status. All this serves to frustrate monitoring of prevalence and control of HIV infection.

Anonymised unlinked testing could solve this problem, but only if it was done routinely on all blood collected for other purposes and was not subject to the informed consent of each patient. I think it a pity that the Department of Health has not exercised greater authority in promoting this approach, which most responsible bodies consider to be justified and ethical. Without compromising the autonomy of the individual person, universal anonymised testing could enable actuaries to take into account the overall risks among different sections of the population and enable insurance companies to be less intrusive to those who take a responsible approach to their health in line with the objectives of *The Health of the Nation*.

BRIAN A EVANS

Department of Genitourinary Medicine,
Charing Cross Hospital,
London W6 8RF

- 1 Barton S, Roth P. Life insurance and HIV antibody testing. *BMJ* 1992;305:902-3. (17 October.)
- 2 Hulme N, Smith S, Barton SE. Insurance and HIV antibody testing. *Lancet* 1992;339:682-3.

EDITOR,—We cannot allow Paul Gibbons's curious concept of life insurance to go unchallenged.¹ He alleges that a claim would not be paid if his death was related to AIDS. There would be little point in having a life insurance policy if certain modes of death were excluded, and it would be unusual for a bank or building society to accept such a policy to protect a loan. Provided the questions on the proposal form are answered honestly and the proposal for life insurance is accepted, the agreed benefit will be paid on death, whatever the cause.

D H MOUNTAIN
G H ROBB

Friends' Provident Life Office,
Dorking,
Surrey RH4 1QA

- 1 Gibbons P. Life insurance and HIV antibody testing. *BMJ* 1992;305:1093. (31 October.)

Decreasing quality of semen

EDITOR,—Time and again supposed evidence for a decrease of semen quality is reported. Carlsen and colleagues presented results of a skilful review of publications on semen quality in men without a history of infertility.¹ On the basis of statistical analysis of data published in 61 studies from 1930 to 1990 they concluded that semen quality has declined during the recent 50 years. They took into consideration that environmental factors might be responsible for both the decrease of semen quality and the increase in occurrence of some genitourinary abnormalities.

We reanalysed data from 48 studies published since 1970 by using the SPSS statistical package and found quite different results. Regression analysis weighted by number of subjects in each study revealed a significant increase of sperm concentration over the past two decades ($B=0.38 \times 10^6/\text{ml}$, $SE=0.02$, $p<0.0001$). R^2 is an alternate estimate of how well the data fits the population. In the above regression model the proportion of the variation in sperm density explained by the model is rather small ($R^2=0.01$), so that this relation, although significant, should not be overestimated.

We conclude from our calculation that the decrease of sperm concentration observed is not a continuous development, at least not for the past two decades. As only few data are available for the

period 1950-70 linear regression is not a useful model to describe the time related decrease of sperm concentration. There is no doubt that the historical values of mean sperm concentration between 1938 and 1969 are significantly higher than those found between 1970 and 1990, but from a statistical point of view there is little reason to claim a linear development and care should be taken when discussing a causal relation with environmental factors.

ANNA BRAKE
WALTER KRAUSE

Department of Andrology,
Clinic of Dermatology,
Philipps-Universität,
D-3550 Marburg,
Germany

- 1 Carlsen E, Giwercman A, Keiding N, Skakkebaek NE. Evidence for decreasing quality of semen during past 50 years. *BMJ* 1992;305:609-13. (12 September.)

Managing transient ischaemic attack and ischaemic stroke

EDITOR,—Martin M Brown and Peter R D Humphrey's comment concerning the lack of suitable patients referred by general practitioners for further investigation of transient ischaemic attack is particularly important.¹ We recently carried out a postal survey of all 122 general practitioners in one district health authority about their attitudes to carotid endarterectomy; we received 102 replies (84%).

Although 61 of the general practitioners thought that carotid endarterectomy was of benefit in selected patients, the remainder either felt unable to give an opinion (36) or thought the procedure unacceptably hazardous (five). The results of the recent international trials had been noted by only 21 of the general practitioners.

The age of the patient was the commonest deterrent to referral (40 respondents) despite the authors' assertion that this should not be a definite barrier. In our sample the general practitioners referred for further investigation only a third of patients whose symptoms they attributed to carotid disease.

Our survey confirms the suspicion that many patients in the community will benefit from investigation and carotid endarterectomy only if efforts are made to increase awareness among general practitioners.

ANDREW J McIRVINE

Department of Surgery,
Joyce Green Hospital,
Dartford,
Kent DA1 5PL

DANIEL J HIGMAN
PETER J FRANKS

Department of Surgery,
Charing Cross Hospital,
London W6 8RF

- 1 Brown MM, Humphrey PRD. Carotid endarterectomy: recommendations for management of transient ischaemic attack and stroke. *BMJ* 1992;305:1071-4. (31 October.)

EDITOR,—After reading Martin M Brown and Peter R D Humphrey's recommendations for the management of transient ischaemic attack and ischaemic stroke¹ I calculated the implications for my district health authority of 140 000 patients and 70 full time general practitioners. About 250 patients have a stroke each year, of whom 100 die within one month, 90 remain disabled, and 60 make a good recovery. A further 60 patients suffer a transient ischaemic attack. Of the 120 patients who make a good recovery or have a transient ischaemic attack, 80 are younger than 75 and would require neurological referral for duplex scanning; this would show that 13 had a