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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Depression in old age

SIR,—I found the sweeping pessimism of your leading article (6 August, p 375) quite at odds with my own experience over the past 10 years as a psychogeriatrician. Professor Millard was, of course, handicapped by his professional distance from the subject he was reviewing, which may explain his apparently unquestioning acceptance of Murphy's conclusions on her own recent research[1] and Post's earlier work[2]; hence his "rule of three" that "no matter what is done, a third get better, a third stay the same, and a third get worse."

I would be the first to applaud the care and skill with which Dr Murphy assessed and followed up her cases, but her report is almost devoid of details on the range of treatments used. I was puzzled at the extraordinarily low rate of success among the small number selected for electroconvulsive therapy; there is no discussion of the place of maintenance antidepressants; as in Post's studies there is also no mention of the use of lithium.

My own experience in a unit adopting an energetic approach to depression in the elderly, making eclectic use of antidepressants, electroconvulsive therapy, lithium, and psychotherapy, and with an extensive follow up service, is very much at variance with that of Dr Murphy. Unlike her I have found the premorbid personality a very useful guide to prognosis and the target for which to aim as the patient recovers. Electroconvulsive therapy is particularly effective in those with "good" personalities who have not responded to other treatments and is often needed for those with the more severe symptoms and notably those with depressive delusions. A characteristic of the elderly, however, is that such courses will often need to be much longer in younger patients and to have lasting effect must be continued until full recovery is achieved. I have also been most impressed by the results of lithium in prophylaxis in both unipolar and bipolar illness in the elderly, particularly in those who may relapse after a stable period of full remission after a course of electroconvulsive therapy. My overall impression is that I see far more full recoveries in elderly patients referred with depression than I used to in the younger clientèle with whom I previously worked in general psychiatry.

I recognise that modern medical practice demands something more tangible than assertions such as these. This underlines a fundamental problem in a specialty such as ours in which those setting up new services tend to be so busy coping with the demand that their effectiveness generates that it is difficult to find the time to evaluate the results. One hopes that the recent initiative of the Department of Health and Social Security after publication of the "Rising tide" report may facilitate such evaluation. I am indebted to Dr Murphy for helping to jolt our noses off the grindstone to make use of this opportunity, though that will inevitably take time. I hope, therefore, that medicine at large will for the moment reserve its judgment rather than accept Millard's "rule of three" as representing the best that we can do for the elderly patients with depression in the 1980s.

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[1] Murphy E. The prognosis of depression in old age. *Br J Psychiatry* 1983;**142**:111-9.
[2] Post F. The management and nature of depressive illness in late life: a follow-through study. *Br J Psychiatry* 1972;**121**:393-404.

Care of long stay elderly patients

SIR,—Dr R E Irvine's review of *Care of the Long-Stay Elderly Patient* (2 July, p 53) shows why it was so difficult for my colleagues and me to develop, over the past 20 years, a civilised and integrated interdisciplinary service for elderly patients. We were up against the deeply inbuilt concept of acute internal intervention medicine, not only in the so called acute specialties but in geriatric medicine itself.

We got very little understanding from geriatricians, even though in our area and our region there was massive acute provision, partly because many were unable to comprehend and partly because the search for respectability lay in turning geriatric medicine into yet another specialty of acute internal intervention medicine. It is far more than this. The dynamics of a geriatric service apparently demand "that the beds for long stay care are reduced to a minimum." "Turnover" becomes the measure of "productivity." It does not seem to matter much how the "turnover" is brought about, whether it is effective or not, even though it is easy to construct a "medicosocial audit."

My colleagues and I soon realised that external influences were often more important than anything else, and we paid particular attention to the needs of relatives and friends. This meant, among other things, that patients were not moved around to get turnover or to fit a system rather than their needs and those of relatives. We saw the great improvement that could come about in people's performance and behaviour. The expression of symptoms often became very much less, and we began to see how unnecessary, how irrelevant, and how inappropriate much, but not all, internal medicine was.