

Sir,
Judy Gilley's paper on intimacy and terminal care made some important and often overlooked points but seemed lacking in breadth. The reader is left to infer a causal relationship between a lack of comfortable sexuality within a marriage and eventual admission of a dying spouse to hospital or hospice.

Many complex and intertwined factors determine where a patient dies; these are difficult either to define or measure. It is certainly ideal to have a spouse as loving nurse, but in the absence of this enviable situation other people may compensate. At best there will be blurring of family roles and the need for nurture within the dying person may be met by parent, sibling, child or dear friend. Physical intimacy in this setting is not so much a function of sexuality as a function of love. I would argue that Mr B.'s screams were not necessarily for a wife who could brush his hair but perhaps for anyone who loved him enough to brush his hair.

The important message these cases convey is that the anguish of losing a spouse accentuates the strengths and faults inherent in that relationship. There may be healing of old rifts or further destruction.

The article concludes by asking us to take the confessions of the carers as cues for the organization of appropriate care. But will this take into account the wishes and the rights of the dying person? These rights are only as real as respect and compassion permit them to be. Dying, like being born, is a time of extraordinary poignancy and importance; we in the primary care team are privileged in our involvement. Our role is to facilitate other carers in the realization of these rights while honouring patient, carers, and the bonds of trust between them. Willingness to accept a lack of detailed understanding of a relationship may reflect respect for the patient's privacy.

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Rubella prevention

Sir,
I was interested to read about the action being taken on rubella prevention in Northumberland (News, January *Journal*, p.47). As a trainee I decided to screen opportunistically for rubella immunity all women aged between 16 and 40 years who consulted me. I searched their medical records for documentation of either rubella vaccination or positive

serology, and if no such information could be found I advised them to be tested for rubella antibodies. Those who agreed were venesected immediately. Women were only excluded from this survey if they had been sterilized, not if their husbands had been.

The records of 156 (57%) of the 274 women eligible for inclusion in the survey contained documentation of protection against rubella. Of the remaining 118 women, 11 refused to have rubella serology, 103 were seropositive and only four were seronegative. These four women were all aged over 30 years of age and none of them had ever been pregnant, but three of them were sexually active.

This survey suggests that the policy of vaccinating schoolgirls aged 11–14 years has been very effective in this area since it was introduced in 1970. However, it was necessary to serotest a large proportion of women in order to discover this as only 53% of women aged less than 30 years old had documentation of protection against rubella.

A slightly higher proportion (63%) of women aged 30–39 years old had documentation of rubella protection, usually in the form of antenatal serology. In contrast, of the 18 nulligravid 30–39 year old women in the survey, only four had documentation of rubella protection. Screening of this group of women was very rewarding, however, as it included the only four rubella susceptible women in the survey.

Many practices may feel that screening all their female patients for rubella immunity is not practical. It may be more realistic to concentrate one's efforts on sections of the population at highest risk. This survey suggests that nulligravid women aged 30 years or more are an appropriate target. As more women are pursuing active careers, and contraception has become more reliable, postponement of pregnancy until well into the fourth decade is chosen by an increasing proportion of women. For rubella infection to occur in any pregnancy is a tragedy, but for the elderly primigravida whose fertility is waning this must be even more devastating.

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Depression in the elderly

Sir,
Jack and colleagues (January *Journal*, p.20) are incorrect in stating that within the last two decades there have been no reports of British epidemiological studies

on depression in the elderly. It seems remarkable that they should be unaware of the work of the US/UK study published in 1983¹ which interviewed 396 elderly Londoners and a similar number of old people in New York, detecting 'pervasive depression' in 12% and 13% respectively. An Edinburgh study published in 1984² found that 5% of a sample of 487 old people were depressed. More recent studies in Liverpool³ and Clackmannan, Scotland⁴ have given further information on the epidemiology of depression in old people in the UK which may not have been available to Jack and colleagues when submitting their manuscript.

It is difficult to know what to make of the results of the study itself. In the light of their comment that the geriatric depression scale⁵ is not a diagnostic tool, it is doubtful whether the scale's originators would endorse its use as an instrument for actual case definition rather than possible case detection. Screening of general practice patients for depression will only help the planning of resource allocation if the significance of results obtained at screening is known. The authors are right to emphasize the importance of longitudinal studies of individuals who record high scores on screening instruments for depression, but individuals with low and intermediate scores should also be included for comparison. Only adequate follow-up studies will reveal the relevance of scale scores to clinical practice and service provision.

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References

1. Gurland B, Copeland J, Kuriansky J, *et al.* *The mind and mood of ageing*. London: Croom Helm, 1983.
2. Maule M, Milne J, Williamson J. Mental illness and physical health in older people. *Age Ageing* 1984; 13: 349-356.
3. Copeland J, Dewey M, Wood N, *et al.* Range of mental illness among the elderly in the community: range in Liverpool using the GMS-AGECAT package. *Br J Psychiatry* 1987; 150: 815-823.
4. Bond J. Psychiatric illness in later life. A study of prevalence in a Scottish population. *Int J Geriatr Psychiatry* 1987; 2: 39-57.
5. Yesavage J, Brink T, Rose T, *et al.* Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res* 1983; 17: 37-49.

Sir,
I must defend Dr Ames' allegation that we made an incorrect statement. In fact we were quoting Dr Henderson and Pro-