The hospital anxiety and depression scale

Sir,

As one of the authors of the hospital anxiety and depression scale I wish to comment on the study presented by Dowell and Biran (January *Journal,* p.27). Their study misinterpreted the purpose of the hospital anxiety and depression scale. It was devised as a clinical guide as to whether depression and/or anxiety may be contributing to the distress of patients attending non-psychiatric departments of general hospital clinics. Its purpose was not to rival the general health questionnaire[1] as a screening instrument for otherwise undefined 'cases' of psychiatric disorder. The two sub-scales of the hospital anxiety and depression scale must therefore be considered separately and it is unfortunate that their study has reproduced the error of an earlier study[2] which presented data in terms of the summation of the scores on the two subscales, using an arbitrary score for definition of the supposed 'cases'. The statement by Dowell and Biran concerning the detection of 50% of cases in their sample is therefore invalid. As regards the data in their Table 1, the finding that 10% of the 394 consulting sample (11+29) may be suffering from an associated, or primary, depressive state and 26% (25+76) from an anxiety state are not unrealistic estimates.

It is important to bring to attention some further characteristics of the hospital anxiety and depression scale. Previous self-assessment instruments were either too long for convenient clinical use, presented concepts of 'depression' and 'anxiety' partly in terms of somatic symptoms thus rendering them less useful in physically ill patients, failed to differentiate the concepts of anxiety and depression or lacked instructions for interpretation of scores. The hospital anxiety and depression scale has attempted to overcome these defects. The general concept of 'depression' is overinclusive since the term is used to cover a wide variety of states of misery or unhappiness and, in devising the hospital anxiety and depression subscale we concentrated on the construct of anhedonia since this provides the clinician with the nearest clinical marker for the biogenic (antidepressant responsive) depressive state.[3]

Finally, may I take the opportunity to advise readers on the availability of the scale? To date it has been made available to users in the UK and Eire by the Medical Liaison Service of Upjohn. This good service must now unfortunately end but users may obtain a copy for subsequent photocopy by stamped addressed envelope from myself.

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3. Snaith RP. The concepts of mild depression. *Br J Psychiatry* 1987; **15:** 387-393.

Future for practice nurses

Sir,

In his leading article (April *Journal,* p.132) Dr Robinson refers to the lack of educational opportunities for practice nurses. It is disappointing that there is no mention in the editorial of the report of the RCGP practice nurses task force.[1] The

recommendations in that report were broadly welcomed by the Royal College of Nursing[2] and have formed the basis for discussions which are currently taking place between that body and the College. The College is also represented on the English National Board working party which is currently examining the educational needs of practice nurses.

In contrast to the situation four years ago when the community nursing review[3] was published I believe that the future for practice nurses is bright. There are still many problems to face including their varied nursing backgrounds, their training needs, the lack of a recordable qualification, their inter- and intra-professional relationships, their professional accountability and the need for a clearer definition of their role in the light of the new contract for general practitioners. As their employers we have a responsibility to help them and their professional bodies find their own solutions to these problems.

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2. Saltman BM. The RCN response to the RCGP task force report. *Practice Nurse* 1990; **2:** 355.
3. Department of Health and Social Security. *Neighbourhood nursing: a focus for care. Report of the community nursing review.* London: HMSO, 1986.

Sir,

There are several points in Dr Robinson's letter on the future of practice nurses with which I would take issue.

Practice nurses were employed initially by general practitioners to undertake tasks which could be delegated to nurses less qualified than district nurses. In addition, because health authority funds have always been finite and community nurses of low priority, additional nurses to undertake this work could not be afforded. Because of this finite nature of budgets nurse managers have to prioritize nursing services. To say that they 'restrict the range of tasks' is to underestimate the process which is involved in keeping these services within budget.

There is a great deal of support within the nursing profession for the nurse practitioner. Overlap of roles occurs within all areas of nursing and medical practice and can only be resolved by discussion and negotiation within primary health care teams. The biggest organizational difficulty of employing community nurses solely within general practice is the provision of 24 hour care.

I believe that if aims, objectives and service agreements are set within each primary health care team, involving all the team members and the health authority nurse managers, many of the difficulties outlined in Dr Robinson's editorial would be ironed out. Clearly if the family practitioner committee is paying general practitioner's to provide certain services and the health authority nurses are carrying them out it is likely that costs to the practice will be incurred.

It is my belief that the health authority provision of community nursing services in the future will be dynamic and geared towards the needs of patients within general practices. Employment by family practitioner committees may come with time and should not be shunned, but they need to develop their new role in managing family health services before they take on community nurses too.

ANNETTE CLAYSON

Two Penny Piece
Dockenfield
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Long term use of benzodiazepines: the view of patients

Sir,

King and colleagues (May *Journal,* p.194) highlight the importance of patients' as well as doctors' attitudes in their study. While I would agree with most of their views,[1] their conclusion that the majority of patients have no idea how their doctor regarded their use of benzodiazepines would not I believe represent the situation nationwide. Having recently completed a survey of general practitioners' attitudes to prescribing in my own health board (Argyll and Clyde) I would suggest from the results that general practitioners have a high level of awareness of the problems associated with long term benzodiazepine use, and are adopting alternative strategies in managing this group of patients.

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Reference

1. Hamilton IJD. Patients' attitudes to benzodiazepine dependence. *Practitioner* 1989; **233:** 722-725.

Screening the elderly

Sir,

I write in response to the letter by Dr Fitton (June *Journal,* p.260) concerning the sample size in the randomized control trial reported in our paper on screening elderly people in primary care.

He is correct in assuming that the sample size was determined by the list size of the practice concerned. In our paper, under the heading 'analysis', we make a statement about the power of this trial as follows; 'a trial of this size has an 80% chance of detecting 6% improvement caused by the care plan intervention at the 5% level of significance, on the assumption that the control group will undergo no change'. As such, the trial lacked sufficient power to detect a difference of 5.3% between the test group and the control group in mortality, given the 10.6% death rate in the test group. We are aware however, that a difference of this magnitude in the death rates, and in other measures taken, may have been significant if the power of the trial had been greater. The power of the trial was estimated before the trial was undertaken. It was anticipated that noteworthy differences between the test and control groups would be detected in a trial of this power, particularly with regard to changes in functional capabilities, morale and scores on the Nottingham health profile.

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Patient as consumer

Sir,

The editorial on the patient as consumer (April *Journal,* p.131) was one of the more misguided opinions I have read on the subject since reading the article by Professors Metcalfe and colleagues in the *British Medical Journal.*[1]

The author, a professor of biomedical ethics, sets out what he considers to be best for the British public. Why not ask the public? They will tell you, as their consumer affairs representatives will do, that they are in favour of more competition and choice.[2]

The thrust of the professor's article is based around the core statement that 'the vulnerability of the recipient of health care is surely incontestable'. He then slides into the traditional paternalistic argument that the public interest is safeguarded by a profession which is trustworthy by