dation for careful and regular blood surveillance, or of the paucity of evidence for its efficacy in general practice. The recommendation of lofepramine for the elderly may be more soundly based as it has fewer anticholinergic side effects but these side effects still do occur.

Unlike Matthews and Eagles, we believe that most general practitioners are qualified to prescribe clomipramine to their patients without referral to a psychiatrist, and that many can prescribe a monoamine oxidase inhibitor or lithium and provide the supervision that is required.

Our advice to general practitioners is based on the evidence of Hollyman and colleagues.[3] Patients presenting with a probable or definite major depressive disorder[4] should be treated initially with a first generation tricyclic antidepressant such as amitriptyline, unless contraindicated. A diagnosis of probable major depressive disorder depends upon persistent depressed mood for at least a week, preferably two weeks, together with at least four of the following symptoms: change in appetite or weight; sleep change; loss of energy; loss of interest; self-reproach; poor concentration; recurrent thoughts of death or suicide; and visible agitation or retardation. Second generation antidepressants have a place as second line treatments where side effects of first line drugs necessitate a change of regimen in spite of the disadvantages. The first generation tricyclic antidepressants are well tried, established in efficacy, have known side effect profiles and are much less expensive than second generation drugs. They are therefore much more appropriate as first line treatments.

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Quality or inequality in health care?

Sir,

During the stimulating debate on 'Quality or inequality in health care' at the Royal College of General Practitioners' Spring meeting in Newcastle, some speakers maintained that general practitioner fundholders were drawn from the better quality practices and that fund holding would further improve the quality of the care for their patients. I was reminded of the paper by Howie and colleagues (February *Journal,* p.48) in which they reported their research which made a convincing case for relating the quality of personal family doctor care to the length of consultation.

Being by nature a 'slow' doctor myself, my work as a locum in various Glasgow practices over the last few years has been enlightening. In some 'quality' practices the consultations were at 10 minute intervals; others had five minute appointments and many extra appointments. In the former I saw 12 patients in two hours and then had time to attend to all the paper work; in the latter, mainly in the peripheral housing schemes, I saw 35 to 40 patients in three hours. I am in no doubt about the quality of care, or lack of it, in these situations.

The main difference is clearly patient demand. In practices in deprived areas where patient demand is high there are substantially fewer patients per doctor than average and therefore the doctors receive less remuneration in capitation fees. There is little time for health promotion clinics and little hope of achieving targets, so income from these activities is limited. Deprivation payments are high but do not nearly compensate, which explains why these doctors are the poorest paid in the UK.

In their paper, Howie and colleagues stated 'doctors generally feel constrained by their commitments and, although many faster doctors expressed dissatisfaction with short consultations, they did not see a change in organization as a realistic option.' The greatest differences they found between longer and shorter consultations were first in the number of psychosocial problems identified and dealt with, and secondly, in the number of other health problems identified and dealt with. My observations (only impressions and not properly researched) confirm Julian Tudor Hart's inverse care law.[1] It is the patients in these areas of high social deprivation,[2,3] with the greatest demand on services and the shortest consultation times, who would benefit most from longer consultation times, where their doctors could try to help solve their problems and offer advice to improve their physical, psychological and social health.[4,5]

The motivation of the doctors in these areas is high and they have been justly called medical missionaries. What has the new contract to offer them? What is the RCGP's role in supporting them? At the very least we must try to keep up their morale and avoid 'peripheralizing' them, like the parts of our cities in which they work.

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Standardized patients in general practice

Sir,

Rethans and colleagues are to be congratulated on their careful and thought provoking studies of the use of standardized patients (March *Journal,* p.94,97). I wish, however, that more emphasis had been placed on a most important caveat towards the end of their second paper. 'The finding that doctors perform below predetermined standards does not prove that doctors are incompetent; it should at least be tested against the hypothesis that standards for actual care are still not realistic'. In other words, an alternative interpretation of the results is that the preset standards of care are invalid because they fit so poorly with the actual practice of doctors who should be presumed to be competent.

In much standard setting work of this type, I suspect that even the best intentioned general practitioners cannot throw off their essentially hospital based education, traditionally so dependent on received (and frequently untested) truths. Intuitive-