

Sleep loss in elderly people

Sir,

We were interested to read the paper by Livingston and colleagues (November *Journal*, p.445) which found an association between subjectively reported sleep disturbance and depression in those aged 65 years and over.

The relationship between sleep loss and affective disorders has many facets. In a study exploring pseudo-insomnia Carskadon and colleagues found that 'approximately half of the subjects who complained of insomnia could not be distinguished from normal subjects by total sleep time or sleep latency'.¹ Pseudo-insomnia, which may be part of a psychiatric illness such as depression or dementia, is an area which highlights the importance of a thorough assessment, both to prevent the unnecessary prescription of benzodiazepines and to exclude other illnesses which may have more appropriate and effective treatments. It also illustrates the difficulties of using self-report instruments in sleep studies.

Livingston and colleagues' suggestion that 'sleep disturbance seemed to lead to depression' needs clarification, particularly as there is mounting evidence to suggest that sleep loss may have a role to play in the generation of mania in susceptible individuals.^{2,3} Depression and mania both belong to the group of affective disorders, the most striking example of which is manic depressive psychosis. More research is certainly warranted in this fascinating area.

In both years of the study benzodiazepines were more commonly prescribed in those who were depressed, whether or not there was reported sleep disturbance, and this was a worrying finding. Approximately 70% of those who kill themselves have a depressive illness.⁴ Approximately 15% of those with severe depression kill themselves and the rates of recorded suicides are higher among those aged 75 years and over compared with any other age group.⁵ Clearly, the identification of depression is important. Diagnosing depression in elderly people may be difficult and any assistance in establishing a diagnosis may be useful. In this context, the finding that approximately 60% of depressed adults experience a marked anti-depressant response when they are deprived of sleep may be important.⁶ Unfortunately the effect is short-lived but sleep deprivation has been advocated as a useful way of identifying depression, and in particular helping to distinguish between the pseudo-dementia of depression and dementia.^{7,8} With the consent of the patient this is usually prac-

ticable in residential or hospital accommodation, and may sometimes be so at home where relatives are in residence.

Sleep loss may therefore be more than an irritating symptom. It may have a role in the genesis, diagnosis and possibly the treatment of affective disorders.

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Reaccreditation

Sir,

The discussion paper by Stanley and Al-Shehri (December *Journal*, p.524) contains much food for thought, but their proposal that 'the ability of general practitioners to learn from experience, rather than competence or performance, represents an appropriate and feasible yardstick for reaccreditation' does not seem convincing. It is not clear what they mean by ability to learn from experience, especially as the methods tentatively suggested for assessing it — such as objective structured clinical examinations and analysis of videotaped consultations — are methods designed to assess competence. Also, although it may be possible to test ability to learn from experience independently of competence (for which it is surely a prerequisite), evidence would be needed of its correlation with performance, which is what matters to patients.

Could it be that compulsory reaccreditation is an overambitious solution to an exaggerated problem? The idea that doctors should undergo periodic reaccreditation seems logical and sensible. However, it is questionable whether it is actually

practicable to provide a system of compulsory reaccreditation which is good enough to serve a more useful purpose than window dressing. Perhaps the time and effort which would be required to develop and run any system of reaccreditation for general practitioners would be better spent, at least in the short term, on improving continuing medical education.

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Fundholding

Sir,

Many salient issues were raised in the discussion paper by Bowie and Harris (January *Journal*, p.38). Nottingham Non-fundholders is a constituency based (using existing social services boundaries) group of general practitioners which has been contracted to advise Nottingham Health Authority on purchasing since January 1993.

We agree that the purchaser-provider split has encouraged providers to become more responsive to the needs of general practitioners and their patients. In collaboration with Nottingham Health Authority we will negotiate contracts for 1994-95 which will substantially reduce waiting times in key specialties and avoid the emergence of a two-tier system in Nottingham.

Bowie and Harris discuss the prescribing, administrative and information technology consequences of fundholding. The assertion that substantial funds have been saved through fundholders' prescribing¹ has been challenged;² indeed the merit of paring prescribing costs has been questioned.³ Nevertheless, we consider it inevitable that the government will seek to reduce drug spending by explicitly linking prescribing and purchasing budgets at health authority level. Overspending of drug budgets reduces the funds available for secondary services since no top up funding is available. This has major implications for the funding available to providers and will galvanize consultants into working with general practitioners in an effort to rationalize prescribing.

The administrative costs of fundholding are unsustainable. If all 200 general practitioners affiliated to Nottingham Non-fundholders were to become fundholders the practice management costs alone would exceed £1million per year, notwithstanding the additional costs incurred by providers and the family health services