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 stiking 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 practicable 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' prescribing[1] 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

authority. The practice management costs of our model are estimated to be less than a 20th of this amount. The National Health Service Management Executive has begun to recognize the potential advantages of alternative models to fundholding.[4,5]

We agree that an improved information system is essential if the purchaser–provider split is going to be made to work. In collaboration with Nottingham Health Authority, Nottingham Non-fundholders have helped to develop and pilot an electronic outpatient booking system which will give general practitioners up to the minute information on waiting times and enable them to book an appointment in the same way as one would expect to book a holiday through a travel agent. Every appointment, from whatever source, will ultimately be logged through this system, yielding an unprecedented amount of information on which to base future planning and purchasing decisions.

We believe our model has the greatest potential for achieving the foxtrot aspired to by Bowie and Harris — between doctors and patients, purchasers and providers — and will ultimately be recognized as the model of choice.

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Sir,

Bowie and Harris have suggested an interesting and logical way to develop fundholding (January *Journal*, p.38). Some non-fundholders have begun to develop along similar lines, with the setting up of locality purchasing groups. In mid-Devon, for example, 15 practices covering 80 000 patients have combined to form the Mid-Devon Family Doctors Group. For this group, as in the Bowie and Harris model, the district health authority is responsible for commissioning, contracting, financial arrangements and billing. Similarly, the group is able to overcome problems with two tier systems, excessive administrative costs, accountability, fragmentation of purchasing and poor use of general practitioner time. Indeed, the only difference between such a group and the Bowie and Harris model is that we foresee the whole group having a notional fund rather than each individual practice.

Groups can provide common purchasing messages, which are helpful in the planning of local services. With district health authority support, there is no reason to believe that they would find it any more or less difficult to keep within budget than fundholding practices, given the problems that have arisen in setting and policing individual practice budgets. Perhaps in such as system, practices should be able to choose whether to hold individual or group budgets.

With the development of fundholding groups as well, fundholders and non-fundholders seem to be tunnelling towards each other. To be effective, non-fundholding groups will need to be able to attend to detail and also to have a satisfactory information base. Help with administration costs and computer development will be necessary. Such help and support will be required in future from the Department of Health and regional health authorities, who will need to show themselves to be fair and open-minded on the fundholding/non-fundholding issue.

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Trainee assessment

Sir,

Dr Mackay (letters, January *Journal*, p.44) voices his opposition to our use of videotaped consultations in trainee assessment.[1] He compares the findings of Martin and Martin,[2] which show that most patients find videotaped consultations acceptable, with his own survey which appears to show that this is not the case.

There are facts which are not clear from Dr Mackay's letter which we believe are of importance in weighing up the evidence. The first point is that the Martin and Martin results were published as a peer-referenced paper, whereas Dr Mackay's study has not been published but has been quoted by him in an earlier letter.[3] Readers have therefore not had the opportunity to see the details of the work carried out nor has there been an opportunity for peer review. One of the details is that of the patients surveyed by Dr Mackay none had ever been asked to take part in a videotaped consultation. The patients were in fact responding to hypothetical questions such as 'how do you think you would feel if you were asked to take part in a videotaped consultation?' Provided that patients are given every opportunity to refuse to take part and that consent is freely given we believe that the use of videotaped consultations in summative assessment is an ethical and powerful tool to detect unsatisfactory doctors, something which can only be of benefit to the public.

While agreeing with Dr Allen (letters, February *Journal*, p96.) that if simulated patients could assess clinical competence reliably the need for direct observation by medically trained assessors would be eliminated, the American experience he describes[4] suggests that such reliability would be difficult to attain and would incur its own resource implications. In the American study it required three weeks to administer tests to 70 students with the resultant generalizability coefficient ranging from 0.61 to 0.72 (optimum 0.80). The test also involved written answers after the consultation which would would clearly require medical input to mark. The cost of developing and administering the test to 72 students was calculated at £26 800. The study by Rethans and colleagues and quoted by Dr Allen specifically states that 'the results in this study do not allow us look at individual doctors'.[5]

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