



who do not have depression and in seven of the 20 who do, giving a total of 27* supposedly depressed patients. Of patients diagnosed with depression 33–43% are given antidepressants.^{3,4} So, out of 27 patients we prescribe antidepressants for 10.

Antidepressants produce improvement in 28–74% of patients compared with 16–35% on placebo.⁵ Withdrawal rates from antidepressants are 3–30%.^{5,6} So, of 10 patients for whom we prescribe antidepressants, two withdraw, three continue without benefit and five continue with benefit, of whom two would have benefited from placebo.

This account omits certain considerations such as compliance and is meant not to be statistically watertight but to give an overview. It indicates the marginal role of antidepressants, the importance of finding out what makes one depressed person consult unlike the other three who don't, and the potential value of depression screening questionnaires.

*By my choice of list size and workload I have arranged for these figures to match: that does not mean they represent the same patients.

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Film on NHS for new immigrants

The work of O'Donnell and colleagues¹

clearly illustrates how recent immigrants' expectations of the NHS are shaped by their experience of health services in their country of origin. When expectations conflict with the reality of service delivery in the UK, patients become frustrated, staff also find themselves under strain. The need to repeatedly explain the system and to cope with unhappy patients, who are having difficulty negotiating appointment and referral systems, can increase the workload.

In response to the challenge of explaining the NHS to new immigrants, I have recently worked with a small group of (mainly) asylum seeker and refugee health professionals to produce a short film, 'How to use the NHS'. The film takes the style of a conversation between two old friends. It is made in English with voice-overs in eight other languages, namely: Arabic, Farsi, Kurdish, Urdu, Sylheti, Somali, French, and Polish.

The key messages in the film cover some of the issues highlighted by O'Donnell's article, and others that my own experience suggested might be useful. For example:

- in the UK, patients receive most of their care from their (well trained) GP, not from hospital;
- most GP surgeries ask patients to make an appointment to be seen;
- patients must arrive on time for their appointment;
- interpreters can be requested for patients with little English;
- help with costs of prescriptions is available for those on low incomes;
- repeat prescriptions can be obtained without seeing the doctor, provided a few days notice is given;
- routine referrals to hospital specialists may necessitate a wait of a few weeks. This is the same for all NHS patients; and
- for advice, and out-of-hours care, NHS direct can be consulted on 0845 46 47 — the service offers interpreters.

The film was launched in Manchester in March 2008. Because we want the film to be used as widely as possible, it is

available on the internet (www.blackhealthagency.org.uk/drupal/video) or can be ordered as a DVD from the Black Health Agency at cost price. Copies have already been requested by agencies as diverse as refugee community organisations, Citizens Advice Bureaux, and tutors of English as a foreign language, as well as health organisations. We believe that going beyond traditional healthcare organisations is the key to getting information out to the people who need it most.

A qualitative evaluation of the film was overwhelmingly positive and provided useful feedback on how it could best be used, in combination with information on local services. GPs working in areas with high numbers of new immigrants, asylum seekers or otherwise, might like to direct their new patients to the film in order to ease their transition into the NHS.

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Diabetic feet

In their recent publication 'Patients' perspectives on foot complications in type 2 diabetes: a qualitative study', Gale and colleagues highlight the discrepancies between clinicians' and patients' views of diabetic foot complications. The authors state that 'this particular study is, to the authors' knowledge, the first to investigate perceptions of foot complications among people with type 2 diabetes who do not have personal experience of ulceration.'¹

We would point out that this topic has been extensively investigated by our group using both qualitative and quantitative methods and that our studies

included both patients with and without previous foot ulceration. The findings of this large Diabetes UK- and American Diabetes Association-funded study have been described in a number of publications.²⁻⁴

The combination of patient interviews with our clinical experience informed the development of the Patient Interpretation of Neuropathy (PIN) questionnaire, an instrument assessing patients' common-sense misperceptions about diabetic foot complications, their levels of understanding of foot problem-related medical information, and foot problem-specific emotional responses that are associated with foot self-care.⁴ The 39-item PIN fully covers the themes described by Gale *et al*; such as, the vascular model of foot complications (PIN: 'good circulation in the feet means that a person will not get foot ulcers on their feet'),⁴ which leads to the engagement in ineffective foot care (PIN: 'Engaging in activities such as walking or massaging my feet can improve circulation in my feet');⁴ or dissatisfaction with practitioners (PIN: 'I feel angry about healthcare providers not telling me what is really going on with my feet').⁴ Additionally, the PIN assesses a number of patient misperceptions that are not described in Gale's study including those that are shaped by neuropathy-related peripheral insensitivity. These, for example, include the belief that the development or worsening of foot ulcers would be accompanied by pain. Importantly, the PIN provides the coverage of one of the most important determinants of foot self-care; that is, patient understanding of ulcer causes with a focus on the intrinsic risks (for example, hard skin formation), as our interviews demonstrated that patients lack understanding about the causal links between diabetes-related nerve damage and ulceration.

The PIN has been validated in a sample of 495 patients at risk of foot ulceration (64% no personal experience with ulcers). It showed good ability in discriminating between those with and without foot ulceration and a strong relationship with foot self-care.

We would therefore encourage GPs to introduce this succinct yet comprehensive questionnaire to their practice as part of a foot risk assessment, as it allows identification of the patients' views and misperceptions about foot complications, which could be attended to during medical consultation. Copies of the PIN can be obtained by logging onto www.dialex.org.

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Palestine

I am bemused on two counts as to why the *BJGP* chose to publish Lesley Morrison's essay — Stories from