

qualified to carry out. Perhaps this is why, in our group transferred within a week, there was a higher incidence of referral from social workers and other professionals. The number of previous psychiatric admissions and age also seem to increase the risks of inappropriate referral.

Colgan & Philpot (1985), studied the routine use of physical investigations in elderly psychiatric patients and found abnormalities in up to 20%. Tench *et al* (1992), comparing pre and post-mortem diagnoses, found a prevalence of physical disorders in psychogeriatric patients similar to those in elderly patients in general hospital wards.

Inappropriate referrals of the physically ill to psychiatric hospitals is unfortunate and wasteful of resources and even lives. Our study suggests that one in 50, 2% of all admissions, fall into this category, if only those transferred within the first week are counted. With more care, such patients could be admitted at the outset to where they clearly need to be – the general hospital!

DAVID PERRY

Central Hospital  
Hatton, Warwick  
CV35 7EE

JAMES EVA

Cell Barnes Hospital  
St Albans, Hertfordshire  
AL4 0RG

#### References

- COLGAN, J. & PHILPOT, M. (1985) The routine use of investigations in elderly psychotic patients. *Age and Ageing*, **14**, 163–167.
- TENCH, D. W., BENBOW, E. W. & BENBOW, S. M. (1992) Do old age psychiatrists miss physical illness? *International Journal of Geriatric Psychiatry*, **7**, 713–718.

#### Dial 'M' for 'memory complaints'

DEAR SIRS

A local newspaper in the Mannheim area advertised a telephone hotline offering 'specialist information' on Alzheimer's disease (AD). Questions about patient care, therapy and perhaps recent developments in basic research were expected. The lines were busy for more than three hours and the 'experts' were surprised by the callers' response.

I received 16 calls. Twelve (two men, ten women) callers complained about unspecific and mild memory disturbances and feared developing AD. Their mean age was 55 years (range 49 to 65) and they described mild forgetfulness lasting from a couple of months up to seven years (mean 2.7 years). Eight of these 12 memory complainers had one or more relatives suffering from dementia, in six cases one parent had been affected. Most said that they were

too embarrassed to discuss this problem with their doctors and most were afraid that their genetic risk of developing AD was 50% or higher.

Only four callers (two men, two women) with a mean age of 70 years (range 59 to 83) sought advice on patient management. No caller from the second group had an affected parent. Younger age together with the presence and number of affected relatives permitted the correct prediction of memory complaints in all but one of the cases. Four other 'experts' received a similar number of calls of the same nature (but they had forgotten to take notes).

We conclude that the fear of developing AD is a major concern of many people in late middle age with mild or imagined memory deficits and with relatives suffering from AD or other forms of dementia. There is a need for counselling these memory complainers and to offer information about the estimated relative risk of developing AD in comparison to the general population. It was our impression that popular descriptions of AD in the lay press may stir up fears by sensitising people for minor, benign deficits. O'Brien *et al* (1992) observed that a finding of clinical normality in memory complainers can be replicated at a follow-up examination in most cases, but that memory complainers have to be taken seriously because their risk to develop manifest dementia was slightly higher than in the general population. This underlines the need for diagnostic markers of AD which are reliable in the preclinical or very early stages of illness.

HANS FÖRSTL

Central Institute of Mental Health  
PO Box 122 120  
W 6800 Mannheim 1, Germany

#### Reference

- O'BRIEN, J. T., BEATS, B., HILL, K., HOWERD, F. *et al* (1992) Do subjective memory complaints precede dementia? A three-year follow-up of patients with supposed 'benign senescent forgetfulness'. *International Journal of Geriatric Psychiatry*, **7**, 481–486

#### GP fundholding and psychiatric practice

DEAR SIRS

In his Keynote article (*Psychiatric Bulletin*, April 1993, **17**, 193–195), Andrew Sims has brought into focus the siting and nature of the contractual flaw in the GP fundholding scheme. It has been long predicted that the GP fundholding scheme was likely to harm the NHS by distorting priorities and undermining planning (Ford, 1990). However, the serious implications for multidisciplinary psychiatric health care delivery have been underestimated.

The freedom to refer people with psychological and psychiatric problems to individual professionals

either in a multidisciplinary (MDT) team or otherwise, together with the ability to employ counsellors within a practice, is a serious contractual flaw in the provider–purchaser system, to the detriment of service provision, organisational structure and the consumer.

First, the creation of a split in the referral pattern to uni-professionals would make the present multidisciplinary service seem unco-ordinated, lacking co-operation, with institutional (provider) inertia. Secondly, counsellors and psychotherapists who can now be directly employed by GP fundholders need not necessarily have acceptable qualifications or accreditation (EL(92)48). There are at present no universal training standards or quality controls for counsellors. Lack of standardisation may mean poor quality in primary care (Puetz, 1993). Until information about expected outcomes, probable benefits and estimated costs of such a practice is obtained, there will be unavoidable saturation of uncertainty in service provision.

Organisations have re-structured and adapted themselves to changes in psychiatric health care delivery in the last few years. The strategic thrust has been a move from hospital base to community, informal uni-disciplinary assessments to formal network of joint communication with statutory and voluntary bodies, and integration of rival professional autonomous disciplines with no formal inter-hierarchy to coordinated multidisciplinary teams with a formalised line of command. This restructuring is not just a process of reorganisation and formal allocation; it is simultaneously a readjustment of people's careers, tasks, responsibilities and a realignment of power and status.

The new patterns of psychiatric health care should be given a fair trial before disorganised market forces borne out of a contractual flaw between providers and purchasers prove that they are ineffective. GPs should have a contractual agreement that signs to an organisational model rather than functional arrangements with providers. If the government's strategic objective (*Health of the Nation*, 1992) is to be met, then fundholding GP's have a moral and legal obligation to help create an organisational climate which fosters co-operation and exchange of information. This interdependency with other parts of the 'whole' health organisation means the full autonomy as suggested by the NHS reforms seems impracticable. Neglecting to put new monitoring and coordinating mechanisms in place would ultimately mean that the consumer has yet again not benefited by another NHS reform. The organisational structure of the NHS needs to become more network like, rather than the continuance of the tripartite arms (primary practice, hospital, community) which GP fundholding schemes will propagate.

Patients' organisations and advocacy groups should monitor the needs of the patients and their carers. A major objective of the 1989 NHS reforms was seen to be an increase in consumer choice. However, extending the choice of purchaser (GP fundholder) for selective referral pattern gives consumers less access to a holistic care in psychological health. What price: a provider charter and or another NHS review? (Ham, 1993).

DARRYL J. J. BRITTO

Royal Shrewsbury Hospital-Shelton  
Shrewsbury SY3 8DN

#### References

- FORD, J. C. (1990) General practice fund holders. *British Medical Journal*, **300**, 1027–1028.  
HAM, C. (1993) How go the NHS reforms? *British Medical Journal*, **306**, 77–78.  
PUETZ, M. (1993) Counselling in primary care? Expectations, values and effectiveness. *Psychiatric Bulletin*, **17**, 169.

#### Insight and psychosis

DEAR SIRS

Drs Perkins and Moodley (*Psychiatric Bulletin*, April 1993, **17**, 233–234) take offence at the notion of insight and my discussion of it (David, 1990). I have much respect for the dedication they bring to their clinical work, including the "Eurocentric" treatment of patients against their will under the Mental Health Act which I have observed first-hand. In print however, they seem to balk at the necessity to provide assertive case management of psychotic patients for fear of imposing attitudes "defined within a psychiatric framework". This is an abnegation of responsibility, in short, a cop-out. Perhaps they should seek a less disturbed client group to work with. Certainly a patient who describes their experiences in terms of "karma or bodily imbalance or disharmony" as described in their article, is in great need of help since they clearly believe they are still living in the 1960s.

My review, long-winded and inconclusive though it was, has generated controversy ever since its publication with no less than two *Lancet* editorials devoted to criticism of it (1990 and 1993), the first intemperate and anonymous, plus much correspondence in that and other journals. The article should have considered cultural aspects of illness. Despite this important weakness, authors from the USA (Amador, 1991), Spain (Peralta & Cuesta, submitted), India (Kulhara *et al.*, 1992), Japan (Takai *et al.*, 1992), Singapore (Tan, 1993) and Australia (Roisin Kemp, personal communication) have found my elaboration of the concept moderately useful, with some provisos.