

annual population growth rate and a , b and c are constants) using an ecological study design.

Population growth rate is a function of life expectancy and birth rate. Thus, in countries with low average annual population growth rates or decline in average annual population growth rates, elderly dependency ratios may be high because of increased life expectancy and low birth rate. This, in turn, may result in increased elderly suicide rates. The average annual growth rate may begin to increase in some countries due to an increase in birth rates. This, in turn, may lead to a decline in the elderly dependency ratios. Moreover, in turn, this may result in a decline in elderly suicide rates. As the average annual population growth rate continues to increase, at a critical point the composite influence of increased life expectancy, increased elderly population size and the increase in the proportion of elderly in the general population on elderly suicide rates may become more prominent. This may, in part, reflect Durkheim's hypothesis that the overall cohort size may influence suicide rates due to competition for scarce resources (Shah and De, 1998).

The same curvilinear (U-shaped curve) relationship between elderly suicide rates and the average annual predicted future population growth rate was examined. Data on elderly suicide rates for males and females in the age-bands 65–74 years and 75+ years for each listed country were ascertained from the World Health Organization (WHO) website (www.who.int/whosis/mort/table1.cfm). The median (range) of the latest available year for data on elderly suicide rates was 2000 (1985–2003). Data on the average annual predicted future population growth rate until 2015 for each listed country were ascertained from the United Nations Development Programme (UNDP) website (www.hdr.undp.org/reports/global/2005/pdf/hdr05_HDI.pdf). Curve estimation regression models were used to examine the curvilinear relationship between elderly suicide rates and the average annual predicted population growth fitting the quadratic equation $y = a + bx + cx^2$.

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Cultural aspects of the patient–doctor relationship

The patient–doctor relationship is central to medicine. This relationship has two fundamental components (Calman and McLean, 1984). The first is the doctor's care, skill and knowledge; the second is information-giving to help the individual

Full data sets for elderly suicide rates and the average annual predicted future population growth were available for 80 countries. Table S1 (available online at www.journals.cambridge.org/jid_IPG as supplementary material to the electronic version of this letter) illustrates the curve estimation regression models, whereby the relationships between suicide rates in both sexes in both elderly age-bands and the average annual predicted future population growth rates were curvilinear (U-shaped curve) and fitted the quadratic equation $y = a + bx + cx^2$; the significance level was at least at the 0.05 level.

How can the average annual predicted future population growth rates predict current suicide rates given that this population growth has not yet occurred? It is possible that this observed relationship was purely due to chance. Also, the average annual predicted future population growth rate may be a proxy measure for other correlates of elderly suicides or other variables may predict both elderly suicide rates and the average annual predicted future population growth rates (epiphenomena). The findings of this brief study illustrate that considerable caution and care are required in interpreting findings from cross-sectional ecological studies exploring potential etiological relationships.

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make decisions. Hence, communication and trust are essential in this relationship.

The problem arises when doctors see patients as sick people from whom to extract information or to whom to impart advice, and they therefore ignore a vital purpose of communication, which is to initiate and enhance the relationship with their patients (Persaud, 2005). Long and Jiwa (2004) found that in 25% of medical consultations, the chief concerns of patients had not been elicited and 40% of cancer

specialists in the study by Fallowfield *et al.* (2002) were found to agree that patients preferred not to know too much about their condition, even if the patients said otherwise.

Because this is such an important issue we have interviewed all the psychiatric specialist registrars in Wales (U.K.) to establish their attitudes and expectations about the cultural factors in the doctor–patient relationship.

Patients expect their doctors to be professional in attitude, to provide expert opinion and knowledge about their diagnosis and management; to be listened to and, finally, to come to an agreed plan of how best to manage their problem jointly. Doctors think they can understand human nature and work with individuals to empower them to manage their own illness as much as possible. This may produce a culture change in help-seeking behavior and views of psychiatric illness in general.

Families can provide care and support, or, in some cases, abuse the family members they are supposed to be caring for. They may influence the course of the illness indirectly or directly in complex cases where family dynamics are playing a role in illness. The contribution of the families into the care of their relatives varies depending on the individual family members and patient involved. Families can be warm, supportive, critical, or protective of the patient. In general, family members don't usually tend to interfere with the patient–doctor relationship except in those circumstances where the family dynamics also contribute to the patient's illness. Generally, the clinician's priority is the patient and his or her well-being, and the relationship with the patient has seldom been undermined by the family's influence. Nevertheless, in some cases clinicians have faced relatives who have attempted to draw them into a situation which could damage their relationship with the patients.

At times, what the patient wants may be at odds with the doctor's priorities in terms of management or treatment; for example, the patient may want an alternative therapy such as acupuncture while the doctor's preferred line of management is pharmacotherapy. The doctors' views are that such alternative treatments are the patient's choice and the doctor's role is to discuss evidence for its effectiveness (or lack of it) compared to prescribed medication or psychotherapy and to make sure it does not interact with prescribed medications. Clinicians agree that the groups of clients using alternative therapies are usually less ill and more psychologically minded.

Most patients see their doctors as professionals without their ethnicity or gender impinging on the doctor–patient relationship. The doctors in our study generally agreed that cultural

differences make the job interesting and that conflicts in the relationship generally arise through misunderstandings. Today patients have far more control over and knowledge about their rights and their illness, which, to some extent, has improved the doctor–patient relationship and allows an agreed management plan to be made and implemented. Clinicians do not think that complaints about medications are a cultural issue, rather they have more to do with education and the ability to follow the logic of medical explanation. The patient has the right to make a choice and the clinician's role is to inform them so they can make an informed choice. It was also found that those with a better education tended to be more challenging and less compliant.

In the course of evaluating and caring for patients, there are occasions when doctors feel “stuck” in not knowing how to respond to certain comments that arise during the interview. The difficulties may result from misunderstandings between patient and doctor or from comments that reflect unstated issues. In both cases, mutual dissatisfaction ensues when these underlying factors are not properly addressed. Furthermore, particularly if feeling uncertain of the reasons for these difficulties or if dissatisfied with the conduct of the interview, doctors may respond in an authoritative manner, which diminishes the patient's ability to participate actively in the interaction. There are many reasons why communicating with patients is stressful for doctors, including the fact that it often occurs under very constrained circumstances that are usually far from ideal in terms of setting and time. Also, sick people are not usually able to converse as easily as when they are well, and are often hampered by strong emotions, like fear of a particular diagnosis or procedure. The research evidence indicates that the responsibility for good interaction between parties tends to be seen by patients as lying much more heavily on doctors' shoulders than in most dialogues. The continuing advance of science in medicine also means that doctors have to make more effort to communicate in lay terms in order to educate their patients about the advances in medicine. This confirms that communication lies at the heart of the doctor–patient relationship. Good communication is the key to making a correct diagnosis and formulating a good treatment plan. A patient-oriented style of communication, an ability to explore and discuss patients' expectations and behaviour, a warm and friendly approach, and an ability to gain the trust of the patient through the provision of well-structured and specific information are attributes that have been found to be effective in influencing patients' behavior (Persaud, 2005). The patient has the right to be

fully informed in order to be able to make an informed decision on all treatment options. Perhaps partnership with the patient is the most important factor in changing health-related behavior. Finally, from the training perspective, it is important to discuss the patient–doctor relationship with all our trainees under supervision.

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Is there a role for psychostimulants in old age depression and apathy?

Psychostimulants (including dexamphetamine, methylphenidate and modafinil) are a broad class of drugs that reduce fatigue, promote alertness and wakefulness and possess possible mood enhancing properties. A recent Cochrane Review of randomized controlled trials (RCTs) up to June 2006 systematically investigated the effectiveness of psychostimulants in depression (Candy *et al.*, 2008). Most of the 24 RCTs included in the review were of poor quality and did not exclusively involve geriatric patients. In a meta-analysis involving three trials (none having geriatric patients), the authors concluded that oral psychostimulants may have a possible antidepressant effect in the short term (up to four weeks) and appeared to be well tolerated. However, the clinical significance of this effect was unclear and the potential medium or long-term benefits and side effects were virtually unknown (Candy *et al.*, 2008).

Despite the lack of a solid evidence base, psychostimulants have continued to have a role in old age psychiatry in some countries, especially as a monotherapy agent in depression and apathy, or as an augmenting agent to standard antidepressant treatment in major depression. They also have been explored in the treatment of other symptoms, such as fatigue and cognitive complaints (Ng and O'Brien, in press).

A possible short-term antidepressant effect for methylphenidate over placebo (as measured by the Hamilton Depression scale, HAM-D) was demonstrated in an eight-day randomized double blind cross-over trial in 16 elderly patients with significant medical comorbidities (Wallace *et al.*, 1995). This was a very short trial with a small

number of patients and a high rate of mortality, making any conclusions tentative. Nevertheless, methylphenidate did demonstrate a short-term antidepressant effect in a very frail and ill population. A recent retrospective chart review at a university hospital investigated the use of methylphenidate in patients over 60 years of age with vascular depression (Mantani *et al.*, 2008). Eleven patients were identified who had been treated with methylphenidate (mean 9.1mg +/- 2.9mg per day; range 5–20mg per day) and 81.8% of them were responders (defined as a decrease of 50% or greater from the baseline scores HAM-D at four weeks). The authors concluded that methylphenidate may be a useful antidepressant in vascular depression. Older studies suggest that psychostimulants as a monotherapy may have a role in treating elderly patients unable to tolerate standard pharmacological treatments, who have significant medical comorbidities such as advanced cancer and stroke, or who are in palliative care settings (Ng and O'Brien, in press). However, RCTs are lacking.

Methylphenidate remains a potential augmentation agent in elderly depression. Lavretsky *et al.* (2006) conducted a RCT comparing methylphenidate to placebo augmentation in elderly patients with major depression who were commenced on citalopram. Methylphenidate or placebo was started simultaneously in 16 patients along with citalopram. An accelerated anti-depressant response was noted by week 3 and there was a greater reduction in depression scores on the combination treatment by week 8. There were a number of drop-outs due to side-effects and intolerability of the methylphenidate. The authors concluded that augmentation with methylphenidate at the commencement of anti-depressant treatment may lead to a faster anti-depressant response and a greater reduction in depressive symptoms.