retrospect, I feel this episode probably reflected the ambivalence of the group regarding new members. At the time I remember being rather mystified and puzzled by what had happened. A further paper could be written regarding subsequent events ...

The authors note their shared "feminist perspective" and their belief "that women often come to believe that they are second-class and entitled to less than men". Their obviously successful group experience may well have assisted their own efforts to demolish this myth. Unfortunately, although the group may have intended to present new female trainees with a helpful role model, I was left with a lingering doubt that perhaps, having been "viewed" by the membership, I had been rejected as unsuitable. Obviously, this personal reaction has many other components, but for women thinking of setting up their own training scheme support systems, it may perhaps be helpful to consider the implications of an 'open' or 'closed' membership earlier, rather than later?

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DEAR SIRS

We are very pleased to see the interest in our paper on support groups for women psychiatrists.

If any woman felt excluded by our group we can only apologise and assure her that this was not our intention. The decision to close the group was taken after long and painful deliberation. However, no-one was in fact invited to join and then denied admission. The only criteria for group membership were being female and associated with the rotation at the relevant time (1983–84). After we decided to close the group we hosted two social events for all the women on the rotation and in fact some of the newer women set up a second women's support group, through the Women's Therapy Centre. Dr Griffin's letter emphasises the desire of many psychiatrists for support and we would welcome further discussion through the *Bulletin* as to how this can best be provided.

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Referrals of depressed patients in a general hospital

DEAR SIRS

The article 'Out-patient referrals of major depression to psychiatrist in Central Liverpool' by Drs B. Green and M. A. El-Hihi (*Psychiatric Bulletin*, August 1990, **14**, 465–467) throws light on an interesting, although not much investigated, area of psychiatry.

We want to share our experiences of depressive patients in a psychiatric out-patient clinic of a general hospital from India. More than 50% of our OPD attendance consists of patients referred from other clinics of the hospital; the rest come directly or are brought by the relations. In an analysis of data over six months (November 1988 to April 1989), 140 patients suffering from depression were referred for psychiatric evaluation from various clinics of the hospital. Interestingly, 132 of them had come from the department of internal medicine. The psychiatric diagnosis included psychotic depression (12.1%), neurotic depression (84.3%), prolonged depressive reaction (1.4%) and depressive disorder not elsewhere classified (22%). An interesting finding was that physical symptoms like subjective weakness, pain in extremities, headache, backache, chest pain, palpitations and giddiness were the presenting complaints in more than 90% of the patients. This was probably why these patients first went to the physician and when they were not found to suffer from physical illness, a psychiatric opinion was sought. Only 10% of the group had an accompanying physical illness and these patients did not differ from the others significantly.

We perceive that those referrals from the physician who finally receive a psychiatric diagnosis can be divided into three sub-groups. The first sub-group is formed by the patients in whom no physical disorder is detected and the physician faces a diagnostic dilemma. The second sub-group consists of patients in whom psychological symptoms are detected by the physician himself. The last sub-group consists of patients with a diagnosable physical illness with accompanying psychiatric problems. Only 10% of the patients had a diagnosable physical illness and, as one expects a higher figure in such patients, it appears that often physicians prefer to treat the psychiatric problems of the patients with physical illness themselves. But when they find themselves in difficulty with the case, they seek a psychiatric referral. Hamilton (1989) also noted that patients with mild depression are frequently treated by the physicians themselves rather than being referred to the psychiatrist.

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