Patients' newsletter

Sir,

Two years ago our practice produced its first newsletter for patients and we are soon to produce the fourth issue. The text is prepared using a desktop publishing computer package, and it is then printed for us by the local health promotion department on four or six sides of A4 paper. We mail a copy to each household in the practice using address labels printed by our computer. A number of patients assist with folding and labelling. In the first issue we ran a competition to decide a title and *Heartfelt* was chosen.

The newsletter has been a good way of communicating with patients, and of developing an identity for the practice. We have used the newsletter to introduce new members of staff, especially trainees, and to announce other changes in the practice, for instance new surgery times. It has also been useful to explain some of the problems we have; one receptionist wrote about the stresses of her job and how she did not just sit all day waiting for the telephone to ring. We have also used the newsletter for health promotion with articles on topics such as child immunization. For the latest issue a patient has written an article on how she managed to reduce her high cholesterol level. Perhaps the next stage is to see if any patients would like to be involved in the production side of the newsletter.

We believe the newsletter has been a success and it has been well received. Mailing a copy to each household is expensive but is the only way of reaching everyone, particularly patients who rarely come to the surgery.

I would be very interested to hear from other practices who have produced newsletters, either as a 'one off' or several issues.

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Somatic presentation of psychiatric disturbance

Sir,

In his study of somatic presentations of psychiatric disturbance in general practice, Dr Wright (November *Journal,* p.459) found that his 'somatic' patients had lower scores on the general health questionnaire and clinical interview schedule than patients who presented with overt psychological symptoms, and that they reported half the number of social problems.

However Dr Wright fails to identify this crucial issue: are the 'somatic' patients emotionally less disturbed than the 'psychological' group; or do they have similar levels of disturbance but are not 'psychologically-minded', and so do not score highly on conventional psychological questionnaires? To address this issue, some other yardstick of emotional disturbance is required than self-report psychological questionnaires.

Psychiatric diagnosis according to formal criteria such as DSM-III (*Diagnostic and statistical manual of mental disorders,* 3rd edition) may appear to offer a way out of this impasse. But even here there is a problem, in that the presence of depressed mood is needed to make a DSM-III diagnosis of major depression or dysthymia. It may be that there are types of depression in which depressed mood is not clinically discernible.

It would be interesting to know what contribution was made by each of the subscales of the 28-item general health questionnaire to the overall difference in scores between 'somatic' and 'psychological' patients. One quarter of items of the 28-item general health questionnaire belong to the 'somatic symptoms' subscale (derived from factor analysis of the 60-item version) which might be expected to yield high scores in the somatic patients.[1]

In a study of 670 general practice attenders (data submitted for publication) my colleagues and I found that patients presenting with 'prominent psychological symptoms and signs' had similar mean scores on the Bradford somatic inventory[2] to patients presenting with 'physical symptoms without organic basis'. Moreover the types of somatic symptoms reported by these two groups were very similar. This suggests that what principally differentiates the two groups may be 'psychological-mindedness', manifested in the presentation of distress in overtly psychological terms, rather than any difference in the experience of somatic symptoms.

But there is another possible explanation of Dr Wright's (and our) findings: that patients presenting with 'functional' somatic symptoms are a mixed group. Some patients belong to the spectrum of mood disorders, though varying in their ability to articulate the psychological component. Other patients may suffer from functional illness which is not rooted in any emotional disturbance.

The use of the blanket term 'somatization' does not add anything towards our understanding of these patients, but only blurs the issues of diagnosis and classification. The development of effective treatment strategies will depend on the ability of doctors to construe accurately what is the matter with each patient who presents with medically unexplained somatic symptoms.

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References

1. Goldberg DP. *Manual of the general health questionnaire.* Slough: NFER - Nelson, 1978.
2. Mumford DB, Bavington JT, Bhatnagar KS, *et al.* The Bradford somatic inventory: a multi-ethnic inventory of somatic symptoms. *Br J Psychiatry* 1991 (in press).

Professional relationships between general practitioners and pharmacists in health centres

Sir,

While it may be appropriate to include a paper by a sociologist and a pharmacist, the article by Harding and Taylor (November *Journal,* p.464-466) does nothing to address the considerable problems in the complex relationship between general practitioners and pharmacists. The authors take three pages of text to state the obvious: communication between individuals is improved if the individuals concerned are able to work together in the same building.

This paper is purely narrative, reporting as it does a study of only 23 individuals and listing nine quotations. There is no attempt at scientific method in the study design. Publishing this paper has done little to confirm your *Journal* as the leading journal of general practice in this country.

Most health professionals work either for the general practitioner (receptionist, secretary or dispenser) or for the local health authority (for example medical, nursing and ancillary staff in hospital; midwife, health visitor, district nurse or domiciliary physiotherapist in the community). Only pharmacists are encouraged by NHS regulations to set up their enterprises outside the environment of the primary health care team since they can earn far more as independent contractors. The annual report of the Prescription Pricing Authority 1989–90 showed that the pharmacist's average income from dispensing fees alone was in excess of £35 000.[1] I question whether this is appropriate use of scarce NHS resources.

The recent failed amendment to the community care bill would have allowed the return of dispensing to the general practitioner's surgery, from which it was removed in 1913. Pharmacists have a valuable contribution to make to the care of NHS patients but the present system which separates prescribing from dispensing in time, place and person prevents