monious and embarrassing confrontation is often avoided by further investigations and specialist referrals. Despite the antipathy doctors often express towards chronic somatisers medical care may become a valued source of social support; when it does the patient is often not seeking relief of physical symptoms but using them instead to gain the interest and empathy of the doctor.[18 19]

The recent theoretical shift towards viewing somatisation as a process rather than a category has led to greater optimism in prevention and treatment. [1 9 20] Kaiser-Permanente, an American health maintenance organisation has claimed, however, that the "over utilisation of primary care physicians by somatising patients" could bankrupt the "health care financing system."[19] There is evidence that such patients can be helped, while at the same time reducing health costs.[20] The National Health Service could benefit greatly from a modest programme of clinical and operational research in this neglected area.

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Approaches to somatisation

Issues of time, consultation style, and practice organisation

Treating somatisation has become a topical issue: the Society for Psychosomatic Research recently devoted a conference to it, and last year the Royal College of General Practitioners published the third edition of *To Heal or to Harm: The Prevention of Somatic Fixation in General Practice*.[1] This journal has also devoted space to the closely related topics of "heartsink" and "difficult" patients[2 3] and to "unrecognised depression" in patients consulting general practitioners.[4]

Identifying the true cause of presenting complaints in patients who may be anything from mildly anxious to seriously depressed is difficult but important—drug treatment, which may be appropriate for severely depressed patients, is less useful in managing patients responding to economic, environmental, or personal stressors. General practitioners often feel unable to do much to help patients change these stressors and may lack the skills and time for counselling. Treatment with drugs, therefore, becomes a practical action rather than the preferred option.

What can be done to help doctors deal successfully with patients who "somatise" their lives? Recently, doctors have been encouraged to take a balanced approach to the physical, social, and psychological components of consultations. [5-9] The value of these developments, however, is difficult to assess, and there is little point in training young doctors to work to such a model when the financing and organisation of British general practice does not encourage doctors to take time to listen to patients. Proposals contained in the new white paper, *Working for Patients*, may make this worse.[10]

At present many doctors work with appointment or "open" surgery systems, which do not allow them time to identify and explore psychosocial problems. Inevitably they find it difficult and stressful to deal adequately with complicated interactions between psyche and soma in the time available. Some doctors feel that they have little enough time to deal with patients' perceived needs without delving into their unacknowledged psychological problems. Some may question their role in dealing with illness other than somatic illness. This approach may appeal particularly to patients who resist making a connection between their presenting a physical problem and any underlying psychosocial component, who resent a doctor steering the consultation away from the somatic towards the psychosocial. In larger practices somatising patients can usually change doctor until they find one who views their complaints as physical and responds by arranging investigations. The current medical climate encourages this: doctors are trained to minimise uncertainty and exclude physical causes for symptoms by ever more tests.

Apart from these problems of incentives, time management, and doctors' style there are issues of records, computers, and team care. General practitioners' notes in patients' records, particularly on psychological topics, depend more on the doctor than on the patient's illness and may convey different meanings to successive readers.[11 12] The distinctive pattern of individual and family consultations described by Huygen[13 14] is often unavailable to the doctor, either because family members are registered in several practices or their notes are filed separately. Concerted action by general practitioners can change the consultation behaviour of whole families, small numbers of whom can create a large proportion of doctors' workload.[2 15]

Given the ever expanding remit of general practice—for example, community care and health promotion—it is difficult to see how general practitioners can provide holistic care for 2000 patients. One way forward would be a reduction in list size without a loss in income, matched by a commitment from doctors to devote this "new" time to their patients. The attachment of appropriately experienced counsellors to the primary care team is another possibility. A third might be the use of standardised psychiatric, psychosocial, and health screening questionnaires,[16-22] to help identify people with

psychiatric and other problems, but this option may be less acceptable to patients and doctors.[23]

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Can general practitioners prevent the sudden infant death syndrome?

Collaborative epidemiological studies are needed

Last November the House of Commons social services committee called for urgent steps to improve the paediatric training of general practitioners. Its report noted that fewer than two thirds of new general practitioners had had vocational paediatric training, linking this with a tendency to misdiagnose the early features of ill health in babies who succumb to the sudden infant death syndrome. Cold weather, minor treatable illness, and absent or unemployed fathers were identified as likely factors in unexpected infant deaths, and the report spoke of "worrying questions about the level of awareness among general practitioners of babies at risk."[1]

Yet will improved paediatric training of general practitioners reduce deaths from this syndrome? The assumption underlying the recommendation is that we understand the course of the syndrome sufficiently well to allow general practitioners and health visitors to recognise early those children who are likely to succumb. Yet the truth is not nearly so clear cut as the committee was led to believe, and unfortunately, the committee failed to take evidence from general practitioners. The frequency of presentation of illness in general practice in the first year of life is extremely high: in one inner city population over four fifths of children were seen with one or more episodes of respiratory illness in the first year of life.[2] Only a small fraction of these children was referred to a specialist.

Studies from a hospital specialist's perspective may unfortunately reach conclusions about community care that are not borne out in reality. For example, in 1978 a preliminary report of the Department of Health's multicentre study of postneonatal morbidity found that 18 features were common in infants who had died suddenly and unexpectedly.[3] The report suggested that several "major symptoms" might be markers of life threatening illness and would thus alert general practitioners to this possibility. These features were non-specific—for example, unusual drowsiness, irritability, an altered cry, being off feeds, or excessive crying.

Subsequent studies testing the predictive value of such a classification showed that these major symptoms were too common in children seen by general practitioners to be predictors of a particular outcome.[4,5] Furthermore, inquiries of parents showed a wide variation about what they termed "irritable," "altered cry," or "diarrhoea." Professionals were also likely to differ in interpreting such terms, a feature that added to the difficulty of using symptoms to assess the seriousness of a case.

About one in every 500 births results in the sudden infant death syndrome. Thus for general practitioners the event is rare, occurring once or twice during a professional lifetime. The diagnosis depends on the thoroughness of the necropsy: the more detailed the investigations the less likely are deaths to fall into this unsatisfactory category.

Given this confusion, what can general practitioners do? They can be aware of those groups of children in their practices who are most vulnerable to the sudden infant death syndrome and ensure that primary care is available. Intensive support by health visitors of families identified as being possibly at risk may also be valuable,[6] but this remains to be confirmed by a randomised controlled trial.

Faced with a baby from a vulnerable group with features associated with the syndrome a general practitioner can arrange either for an intensive review by himself or herself or another member of the primary care team or for admission to hospital. In a deprived area, however, many babies may fall into this category and the resource implications of intensive management or admission may be considerable, possibly resulting in detriment to the quality of care for the remainder of the practice. General practitioners are constantly balancing the investment of time and resources against the likely returns. Without any method of more precisely targeting the efforts of doctors or even knowing whether they are beneficial in preventing a rare event the recommendation of any clear strategy for preventing the sudden infant death syndrome in individual subjects is unlikely.

What we need is more community based research entailing collaboration among general practitioners, epidemiologists, and paediatricians. This should develop a reliable classification of illness, particularly respiratory illness, which might be used as the basis of studies of prognosis in general practice. Such studies might allow general practitioners to identify vulnerable children more precisely and allow