indeed I fear most, rehabilitation, convalescence and hospice style care are not available, or only inadequately so, and I believe it would be more useful to our profession if professors and powerful departments of medicine for the elderly were to bombard health authorities with clear evidence of the need for adequate services of this kind to supplement and complement the acute resources. I agree that if we had them we might be able to reduce the inappropriate placement in highly technical sophisticated departments designed for the purpose.

I also emphasise the need to have areas of excellence in pain management, respite and terminal care, in which to train young doctors, facilities we shall soon lack, if we rely exclusively on private sector nursing homes.

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Setting up interdepartmental peer review

Editor—As a collegiate Member, I read the article on Medical audit submitted by The British Thoracic Society's scheme entitled 'Setting up interdepartmental peer review' (July/August 1995, pages 319–24) with interest.

I wondered how many, if any, of the 23 units reviewed had also been through the King's Fund accreditation/inspection process? We at our hospital went through this process some two years ago and there seem to be many striking similarities between the King's Fund procedures and the Thoracic Society's scheme. For us it seemed to many that it was the long drawn out and extensive preparation for the visit that was of the most value, rather in the same way that it is the preparation for an examination that is important rather than the actual taking of the test itself.

Is it thought that the kind of peer review recommended by The British Thoracic Society is complementary to a King's Fund visit? Where both visits occurred were the results similar, and would the logical thing to be to opt for the one rather than the other, or for both?

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The psychological care of medical patients

Editor—Dr Peter Daggett (July/August 1995, Letters to the Editor, page 368) touches on a problem which the President has seen as a major one for physicians (RCP *Commentary*, October 1992, pages 6–7). As he points out, a large number of patients in general medical clinics have somatic symptoms resulting from their emotional problems. In the majority of these, the symptoms are the somatic manifestations of the physiological responses to anxiety such as muscular contraction leading to ischaemia and pain, or hyperventilation (which may be far from obvious) leading to a range of symptoms, from numbness and dysthesia through ataxia to depersonalisation. The fact that the patients do not have visible pathology does not make them 'worried well'—they would not be consulting the doctor if they were well.

How can Dr Daggett deal with his patients if he has merely the negative results of a series of investigations and has not made a positive diagnosis? Before ordering the unnecessary and often expensive investigations he should ask himself what further avenues need to be explored in order to make a diagnosis and not merely what investigations can he ask somebody else to do. Usually, these avenues include a systematic review of the history with a consideration of *all* aspects of the patient's life and a detailed examination of the symptoms with the aim of throwing light on their pathogenesis, as well as a careful listing of all associated and previous symptoms.

If the doctor has considered every aspect and not only selected aspects, he will not need 'to tell the patients that they have psychological problems'—they will tell him. If he has established the pathogenesis, he will be able to satisfy his patients with an explanation of their symptoms. A positive diagnosis is essential; the absence of a 'medical diagnosis' is no evidence that the patient has psychological problems.

If a diagnosis has been made and the pathogenesis and aetiology established, he should be told that his very real symptoms are not the result of structural disease but are the result of the way the body responds to anxiety and tension. The mechanism and aetiology of the symptoms should then be reviewed in a way that ensures the patient understands, for example explaining that tightly contracting muscles hurt.

Sometimes the physician may need to ask for the advice of his psychiatrist colleague. One can only hope that the report of the working party on psychological care of medical patients may lead to an increase in the availability of this kind of advice from both physicians and psychiatrists.

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Editor—We welcome the above report of the joint working party of the Royal Colleges of Physicians and Psychiatrists [1] (May/June 1995, summary of report, pages 192–3). The subject has featured prominently in the psychiatric literature, but has received very little attention from physicians. Patients with psychosomatic disorders as well as those with psychological problems co-existing with medical disease, are some of the most challenging to look after and training to prepare us for this work is scanty.

An audit of levels of psychiatric morbidity amongst medical inpatients at a district general hospital, using the Hospital and Anxiety and Depression Scale [2]

revealed levels between 20 and 40% depending on the group of patients studied. This level of psychiatric morbidity corresponds with studies of other patient groups [3]. Following this audit we have started a programme of teaching for junior staff in recognising psychiatric problems among medical patients.

We feel that good psychiatric skills in all medical and nursing staff whatever their specialty is central to combating the problem of unrecognised psychiatric morbidity. Training should start at medical school with liaison psychiatry forming a central core of psychiatry teaching as well as featuring during non-psychiatry attachments. Further skills should be developed through hospital postgraduate teaching programmes.

We hope that the publication of the report will result in a better service for this group of patients, and that managers and purchasers will realise that liaison psychiatry is an essential part of hospital practice.

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The great insanity

Editor—Dr Pyke asks in his Fitzpatrick Lecture [1] how it was possible 'that such a developed and cultured country as Germany should fall into the abyss of Hitlerism' and says that we must go back 'a few years' in an attempt to answer this. We must, in fact, go back at least 100 years. In a paper given in London in 1987 [2], Professor J E Meyer of Göttingen referred to a book published in 1895 [3], which gave the State the right to kill incurable people and in 1920, Binding, a lawyer, and Hoche, a psychiatrist, published their book *Permission for the extermination of worthless life* [4]. According to Meyer, the ideas put forward by these authors were *never* rejected by any German doctors or lawyers and were eventually put into practice by the National Socialists. In 1940, *before* Auschwitz, 10,000 people were gassed at the Samaritan Foundation for Cripples at Grafeneck [5,6]. In his recent book [7], Michael Burleigh, reader in international history at the London School of Economics writes of 'the complicity of those social groups whose traditional role is supposedly to uphold standards of moral behaviour'.

To assert that 'antisemitism in Germany was slight and scattered since only 1% of the population was Jewish yet 15–20% of the professors were Jews' is simply untrue. Ringer [8,9] has made a thoroughly documented study of the issue. He records that in 1910 12% of the instructors (Privatdozent) were Jewish and 7% were Jewish converts to Christianity. Yet in the higher academic ranks, where Civil Service positions were almost closed to Jews—fewer than 3% of full professors were of the Jewish religion and 4% were converts (and the reason for conversion was to secure promotion which was otherwise impossible). Ringer states that from 1910 to 1930 this situation remained unchanged. There *was* less antisemitism in Germany than in Austria and Freud found his visits to Berlin refreshing [10] despite the fact that there was not one Jewish full professor there at the time.

Pyke bases much of his paper on the records of the outstanding work of the Academic Assistance Council and its secretary Tess Simpson, and says he has spoken of scientists rather than clinicians 'whose record with regard to our medical colleagues was much less good'. Sadly, he does not mention the deplorable record of the medical establishment in England. In 1933, Dawson, President of this College, together with the President of the Royal College of Surgeons, led a deputation to the Home Secretary in an attempt to prevent the entry of German refugee doctors; the BMA and especially the Medical Practitioners' Union, took the same line. From June 1933, foreign physicians were required to spend two years instead of one year in the process of taking their qualifications and Dawson had hoped to persuade the Home Secretary to persuade the Scottish colleges to raise their requirements as well. The Home Secretary refused to do this and the view of the Scottish colleges, to their credit, was that it was their duty 'to protect the public and not the medical profession'. At the meeting with the Home Secretary, Dawson went so far as to say that the number of refugee physicians who could usefully be absorbed 'could be counted on the fingers of one hand' and that his Council fully supported him in this view [11,12].

As Meyer points out, there has been a consistent failure by the medical profession in Germany to admit the situation. In this country, there was goodwill on the part of many individual physicians, as Pyke describes. However, we believe that it is only by facing the historical facts the atrocities perpetrated in Germany can be understood and hopefully prevented in future.

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