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]