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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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

close collaboration between professions: abolition of the community pharmacists' monopoly would bring dispensing back into the surgery. Allowing doctors to sell 'over the counter' would benefit patients and result in considerable savings to the NHS budget, which currently duplicates costs in supporting both general practice and community pharmacy. Moreover, general practitioner and pharmacist would work more closely if they were partners or if the one employed the other.

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Postnatal depression

Sir,
I was extremely interested to read Dr Richards' review article on postnatal depression (November *Journal,* p.472). As the author of the first prospective study on this subject[1] I would like to add two further comments.

First the occasional severity of this type of depression must be recognized. In my series the criteria for inclusion in the depression group was attempted suicide or serious threat of suicide and the incidence was 2.9%. Secondly with regard to previous mental illness I used two control groups. The first included pregnant women in whom depression did not occur, the second a 10% sample of the practice female population aged 15–45 years. A history of previous psychiatric disorder was present in 45% of the depressed group compared with 7% of the pregnant controls and 25% of the practice female population sample.

Having treated patients with postnatal depression for over 30 years I endorse all Dr Richards' comments and hope that as a result of reading his article our colleagues will become increasingly involved in the prevention, diagnosis and treatment of what is a most distressing disorder to the patient and her family.

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Reference

1. Tod EDM. Puerperal depression. A prospective epidemiological study. *Lancet* 1964; **2:** 1264-1266.

Sir,
I must congratulate Dr Richards on a well presented review of the literature on postnatal depression.

I have often found when counselling women with postnatal depression that there are difficulties in mother–child relationships elsewhere in the family. These can be various but the circumstances surrounding the birth that has precipitated the current episode of postnatal depression will often have a link to earlier events. Thus it is common to find that the woman's mother suffered depression after the birth of the present sufferer, or that the sufferer's mother was depressed after the birth of her second child and the sufferer has recently delivered her second child. In one of my patients, the sufferer became depressed when her child was three months old and was very aware of her sister's loss of a child by cot death at three months old. In addition, the sufferer may have felt rejection when a young sibling was born and some of these feelings can recur when her own younger child is born. The present sufferer will thus have 'learnt' that a particular birth order or type of event surrounding a birth is equated with depression or perhaps with sadness and grief.

Examining earlier events and looking for possible connections often seems to be therapeutic and women seem to recover quickly if a plausible connection is made. I suspect that acknowledging the original sadness enables the mother to establish a better relationship with her child and will help to avoid further episodes of depression, but I have yet to establish this.

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Effects of the new contract

Sir,
The editorials by Hart, and Horder and Moore (November *Journal,* p.441-443), together with the letter on budget holding by Sykes (November *Journal,* p.480) brought together some important themes for discussion. Here, attention is focussed on the possible effects the new contract may have on the doctor–patient relationship.

Many of us could see the organizational implications of the new contract a year or so before it was implemented; what we could not have foreseen was the extent of managerial inconsistency nor the administrative inaccuracies and procedural trivia which have resulted. Grafting such a radical change onto an ill-prepared and incomplete infrastructure seems to have been a recipe for chaos.

The current excessive preoccupation with procedures not directly related to patient care may cause general practitioners and their staff to lose sight of their primary purpose. To quote Sir James Spence, 'The essential unit of medical practice is the occasion where, in the intimacy of the consulting room, a person who is ill or who believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and *all else in the practice of medicine derives from it'* (my italics). The real key to 'outcome', according to Spence, is the quality and effectiveness of the consultation, which in turn is dependent on the skills of the doctor, on the time spent on consultation and which is not directly related to the general practitioner's income.

It is understandable that under conditions where future income is vulnerable and therefore unpredictable, other activities — some of which are related to income generation — will invade the time available for consultation sessions. These activities include chasing and attaining targets for immunization and cervical cytology; so-called health promotion clinics — most of which have dubious value and some of which are frankly embarrassing; and assorted activities peculiar to the new contract such as surveillance of the over-75 year olds and screening patients not previously seen in the last three years.

Of course all these items can be delegated, but delegation itself requires planning, discussion and monitoring of execution to be effective — and even good managers have only so many hours in a day. The net result is that consultation time suffers and there is ample evidence shorter consultation times result in more inappropriate referrals and prescriptions. This is not only a quality problem, because both these activities generate the greatest part of a general practitioner's expenditure within the NHS.

By what criteria will a 'good' doctor be defined? — is it the one who rips through the clinics at a rapid rate, or the one who takes longer and who has longer waiting lists? Will the 'good' doctor have his good qualities plundered by the self-defeating strategy of increasing his list or money following his patients? This is not just a rhetorical question since this is how this government sees the 'good' doctor being rewarded.

It is my fear that cost-effectiveness will become a dominant force in the doctor–patient transaction, and that this could transform the relationship in the way that, for different reasons, it appears to have done in the USA. Will audit become the handmaiden of a cost-containment exercise, completely divorced from quality of care? If the educational component of medical audit is ignored in favour of an end of year balance sheet we will have