

Pampallona, S., Bollini, P., Tibaldi, G., et al (2002)
Patient adherence in the treatment of depression. *British Journal of Psychiatry*, **180**, 104–109.

Peveler, R., George, C., Kinmonth, A.-L., et al (1999)
Effect of antidepressant drug counselling and information leaflets on adherence to drug treatment in primary care: randomised controlled trial. *BMJ*, **319**, 612–615.

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Authors' reply: The point raised by Mr Lawton-Smith is of the utmost importance, but we found no published randomised studies that considered patients' perspectives as an entry point for interventions to improve compliance. To fill this gap, our group has recently completed a qualitative study involving patients, families and therapists to identify their concerns with adherence and to design effective interventions. We agree with Mr Lawton-Smith that much remains to be done to adapt research methodologies and clinical practices to the needs expressed by people with mental illnesses.

Vergouwen & Bakker incorrectly attribute our statement, 'the important relationship between adherence and outcome of treatment has been evaluated only in one study' to randomised interventions, when it referred to descriptive studies, both in the Results and Discussion sections. Out of the 14 randomised interventions we reviewed, only five reported data on response which could be extracted. In addition, the design applied by the five studies made it impossible in our review to explore the relationship between intervention and response.

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Cost of somatisation

Steven Reid and colleagues (2002) have introduced a welcome addition to the UK literature on somatisation with their clear demonstration that unexplained symptoms may be associated with significant use of secondary care health care resources. They emphasise a key point, repeatedly

demonstrated, that somatisation is expensive for health care systems. However, their report may tell us more about the behaviour of doctors and health care systems than the behaviour of patients.

By selecting only frequently attending patients, they have controlled for the most important variable in cost of out-patient care, the cost of out-patient attendances. Their own figures show that the costs of attendances represented 74.5% and 85.9% of total out-patient care costs for somatising and non-somatising frequent attenders, respectively. They refer to a major US study (Escobar *et al*, 1987) which demonstrated very high rates of use of secondary care medical resources among patients with separately diagnosed somatisation. By controlling for attendance in their study design, they have almost certainly diluted the apparent impact of somatisation on secondary care use in this sample – an impact they rightly emphasise.

For a significant number of these frequently attending patients, negative investigations were followed by a repeat of the cycle. Those with repeatedly unexplained symptoms were designated 'somatisers' by the authors, implying a disorder in the patient. The medical response to these symptoms may in fact be as important in explaining continued resource use. The reasons why doctors behave in these characteristic ways are less than clear – our inability to live with uncertainty, our unwillingness to go with our judgement. Recent attempts to emphasise the importance of the issue are welcome (Bass *et al*, 2001), but until we more clearly understand doctors' behaviour when faced with these patients, we may remain simply counting the considerable costs.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

Escobar, J. I., Golding, J. M., Hough, R. L., et al (1987) Somatization in the community: relationship to disability and use of services. *American Journal of Public Health*, **77**, 837–840.

Reid, S., Wessely, S., Crayford, T., et al (2002) Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. *British Journal of Psychiatry*, **180**, 248–253.

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Recruitment of psychiatrists

Brockington & Mumford (2002) and Storer (2002) target a topic of major concern in their thoughtful papers on recruitment to psychiatry. I was particularly interested in the comments on 'Background factors affecting the recruitment of psychiatrists' (pp. 308–309). In 1998 an article of mine was published concerning a small-scale survey of the characteristics of consultant forensic psychiatrists (Prins, 1998). As part of this survey, I asked 37 consultants (of whom 30 replied) what had led them to take up (a) psychiatry and (b) forensic psychiatry. (Other questions concerned attractions and difficulties in the latter field.) I am concerned here only to detail some of the responses to question (a). I discovered that some clinicians have indicated background influences publicly. For example, Professor Pamela Taylor has stated that, 'Two of the more powerful influences in my personal background were chronic, deteriorating neurological illness in the family, and the Church' (Taylor, 1997: p. 20). Professor Robert Bluglass has written with considerable candour and humour about the persistence of his early efforts to enter medical school (Bluglass, 1996: p. 96). Less publicly, some of the respondents referred to similar experiences – for example, serious illness or exposure to the suffering of others, particularly within the family or as a result of experiences in the armed forces. Several came from backgrounds in medicine; interestingly, for some, school influences seemed very important. Overall, a dominant theme that emerged was of an interest in people rather than in 'illness' *per se*. However, a few appeared to have entered psychiatry almost by default (the word is not used here in any pejorative sense): 'I was too clumsy with my hands for surgery'; 'I was not physically suitable'. Mine was a very small-scale survey but happily confirmed by Brockington & Mumford's findings; namely, that a decision was taken at a fairly early age to enter medicine, with a later decision to enter psychiatry. These seemed to be determined largely by a feeling of lack of satisfaction with the less personal and holistic aspects of other specialist medical practice. Since schools and other early experiences seem to be quite influential, it may be that more attention should be paid to this aspect than has been the case hitherto. The interesting