remarkably healthy for their age. The problem of social need in the elderly is, unfortunately, different.

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DISCUSSION

Dr B. E. Daly: As a parent, can I prevent my own children developing psychiatric illness or becoming social misfits in life?

Dr Grant: This is one of the points on which I plead the ignorance of psychiatry on all aspects of personality development. The thing that we can do is to give our children the sort of environment in which they can develop and grow up and can realize their potentiality to the fullest possible extent. This does not mean that there will not be things in their personality that will show later on, but it does mean that such things will be reduced. It also prevents irritations which we know very definitely can cause disturbance later on. We must not try to give the things that have been emphasized in family life to the exclusion of other things that we do naturally, but we should perhaps try to ensure that children have those things which much research has shown to be very necessary. I have mentioned some already—the kind of security of acceptance in the family, irrespective of what happens or what they do; a stability in the reactions of those around them; it does not matter much whether the discipline is firm or lax, though this sounds dreadful coming from a psychiatrist. It does not matter whether we think the family is good or bad, or whether the house is clean or dirty, but if there is stability the child has the opportunity to grow and develop. Affection is very important, the warmth of relationship that allows the child to develop in relationships and in its own feelings as well. Very important, but especially important perhaps in view of how little we really know, is to give the child freedom to grow up.

Dr D. J. Sterling (*Co. Down*): What is the significance of a child of ten

years of age sucking her thumb and biting her nails? What line of treatment should be adopted?

Dr Grant: Most children go through a stage in which they suck their thumb and bite their nails; this is part of the normal development of childhood—the part that the psychoanalyst calls the oral phase of development. Some of us never completely leave it, because we use cigarettes or pipes to do exactly the same thing. When a child sucks its thumb, it means that it is regressing to an earlier stage of development because it may be feeling unloved or insecure. Insecurity is an element of our everyday life which we have to face. As far as this ten-year-old child is concerned, this is a normal stage of development. Perhaps there is some stress, some tension, at this moment, but this is not important. The ultimate treatment is to allow the child to find its own security and, as an immediate measure, to try to find something else for the hand to do.

Dr R. P. Maybin (*Co. Down*)*:* How can the family doctor decide whether to deal with a social problem himself or refer it to someone else for help? Would you Dr Grant and Miss Paterson, discuss the role of the psychiatric social worker in general practice?

Miss Paterson: The first question is whether you *decide*? On what criteria do you base your decision to use a consultant? This is the first point. You may want further knowledge, further enlightenment, someone who knows more intensively a part of the subject but does not have your wide basic knowledge. You may decide that this is something you want to deal with yourself although you may ask the consultant's opinion—but you do not necessarily refer the patient to him. Now in this way you can also use the social worker; you may ask the social worker to deal with the patient or you may use her advice to enlarge your imagination about the problem; either of these would be appropriate.

Dr Grant: Yes, I would agree with this completely. I think it very much depends on the interest and the skill of the individual family doctor. After all, psychiatric illness is in this respect similar to other illness; if we are not sure of the diagnosis we invite a second opinion. If we are sure of the diagnosis and we do not have the necessary facilities to treat the patient, we send the patient to where the necessary facilities and the necessary skilled people are. If on the other hand we are sure of the situation, and feel ourselves competent to deal with it or have been trained to deal with it, and have time to deal with it, there is nothing to prevent us from dealing with it. Psychiatrists and general practitioners have begun to realize that the psychiatric social worker is not only a person skilled at finding out information—this is what we used to use them for, to do our case history records for us—but skilled in what is known as 'case work', dealing with the individual in the social situaion. This is extremely important not only when the general practitioner is treating the patient, but also when the specialist is treating him.

Miss Paterson: I find among general practitioners a desire to lean on the psychiatric social worker who makes life easier for them, taking all their problems from them by dealing with all the difficult, unco-operative, unlovable patients. You must realize that I have a trade union point of

view to put here; my own personal view is that the psychiatric social worker will be able to help you with all your high users, the hypochondriacs and so forth, but she may be very limited in her basic medical knowledge which forms quite a considerable part of the medical social worker's training. You have to know what you want before you decide which social worker you need.

Dr R. J. Millar (*Ballynure*): I have a full-time health visitor attached to my practice. When for example it is found that a home help is necessary the case has to be referred to county welfare, and a lot of work is duplicated. Can anything be done to improve the integration of these services?

Miss Paterson: This is a point which is troubling everyone just now—the fragmentation of the social services and the specialties of the different types of workers. On Friday evening I was talking to a group of general practitioners, chief welfare officers and so forth; the point came up that, because of their historical background, different services are carried out by different people. I think it is only when we move into the period (suggested by the survey of social services done in Buckinghamshire) when all services are based on the general-practitioner's surgery, that we may find things a little better. There is an inevitable fragmentation just now, and passing of problems from one to another agency, because this is the way it has been set up in the past. These difficulties are being appreciated, and probably will be less in ten years time.

Dr F. D'Arcy (*Rosslea*): This question concerns nocturia, a bugbear in many middle-aged and elderly but otherwise healthy people; not *per se* but because it breaks up their sleep. Is there any drug which can alleviate this condition?

Dr Elmes: You can prevent single nocturia in a middle-aged or elderly man who has not got organic disease of the urinary tract by adjusting his food intake so that he does not take a lot just before he goes to sleep. It may be the early symptom of an obstruction that requires treatment, but drug therapy would be advisable for the symptom. If you fail to prevent the nocturia and the physical or organic cause for it cannot be controlled, then you are left with the problem whether or not to give a sleeping tablet to be taken when the patient wakes up. Here again it is an individual matter. If a patient has difficulty in going off to sleep, he may be under the impression that he has lost more sleep than he actually has, and a lot of people have very fixed ideas on how much sleep they need. A great many of these people come complaining of insomnia, when in fact they are getting plenty of sleep. In other words, a few of them may require a sleeping tablet because of failure to deal with the matter in any other way.

***Question*:** Would Dr Grant agree with the statement that 50 per cent of patients attending a general practitioner have psychiatric illness? What can a family doctor do, having in mind his work load, except refer these patients to a psychiatrist? If all these cases were referred to psychiatrists as outpatients, how could the numbers be dealt with?

Dr Grant: The published figures for proportions of psychiatric illness in general practice vary from 30 per cent up to as high as 70 per cent, the average being 47 per cent. What a general practitioner can do when he

sees a patient with psychiatric illness comes back to an old problem, for that part of his decision will depend upon his own interest and his own skills. Certain of those patients, once he has made a diagnosis, must be sent to a psychiatrist—those that can only be treated in hospital, or need some special facilities. He will be doubtful about the diagnosis in some cases, doubtful whether the patient has an emotional disturbance heralding a major mental illness, and he will then send him to the psychiatrist for a second opinion. The psychiatrist will probably be doubtful too, but he will take the patient in for observation and thus get out of the difficulty. The difficulty in diagnosis will mean that a patient must go to the specialist or to special facilities. Having disposed of these patients the general practitioner will be left with a large number of patients who should be treated, and his case load is so high that he cannot cope with them all. If he sends them to the psychiatrist they may have to wait a long time for an appointment and perhaps afterwards will not apparently be any better supervised than if the practitioner had kept control of the case. I think this is a very real problem.

One solution is to find more general practitioners, more psychiatrists, more people skilled in treating this type of disorder. One possible theoretical solution is for the general practitioner to select the type of care; there might well be a large number of people who would be handled better by someone other than the psychiatrist, other indeed than the general practitioner. I know it's treading on dangerous ground but perhaps this is one of the places where not only the psychiatric social worker would help us—she does in any case—but also non-medically qualified members of 'helping professions'. Clergymen are one group. Many of these problems have a spiritual element and perhaps we can train a generation of clergymen who will not become expert psychotherapists or *pseudo*-psychiatrists but help in the sense of listening and encouraging, to do what general practitioners feel would be helpful under the general supervision of the general practitioner or the specialist. This is a possible way out of our difficulty of staffing, and I agree that it applies to psychiatrists as it does to the general practitioner.

Dr J. P. Gallagher (*Glenary*): What do you think of Mist. Pot. Brom. and reassurance in treatment of malaise etc?

Dr Grant: Reassurance at all points is valuable treatment. One of the things we have to do is to reassure patients on a factual basis. It would be quite wrong for me as a doctor to reassure a person who had a treatable carcinoma that everything was alright and there is nothing to worry about. I must also give appropriate treatment. It would be equally wrong for me to reassure if I was uncertain what the situation was, but reassurance in the light of known knowledge, bearing in mind the wide areas of ignorance that we have, is a very good thing. I am not so happy about bromide as a drug. It causes spots and all sorts of difficulties; but apart from that, a mild sedative is often a very useful temporary measure to allay anxiety, to allow the situation to be assessed; to give an opportunity for the individual patient to arrive at some stability—often with the help of good friends; or the general practitioner or the specialist if necessary.

Dr Montgomery (*Belfast*): In Dr Carey's survey, how were cardiovascular diseases ascertained by the health visitor?

Dr Carey: The symptoms of cardiovascular disease were complained of by patients first in response to questions right at the beginning: how do you assess your health? How do you feel? If a response was not forthcoming, the health visitor asked about particular complaints and the patient would say "I am being treated by my doctor for angina pectoris" or "I have got palpitation" or "I have got a congenital heart lesion", or something like that. Information about cardiovascular disease was also obtained in some instances, in answer to questions on mobility. If mobility was restricted; the health visitor has to find out why it was restricted. This might be because of an arthritic condition or a cardiac condition and sometimes the patient mentioned the latter at that stage. The complaint might be detected in answer to questions such as: When did you last see your doctor? Was it three months ago, and if so, for what? Are you under medication? Very often the medication would be mentioned at that point and this would lead us back to a diagnosis of heart disease. There was no part of the questionnaire specifically devoted to the diagnosis of cardiovascular disease or cardiorespiratory disease. As to haemoglobin levels, I have not got Dr Malseed's figure here, but I recollect that the men attending the doctor had haemoglobin levels of about 94 per cent and those not attending their doctor about eight per cent lower, but this was of no statistical significance. The women, whether or not they had attended their doctor, had about the same levels as the men who had not attended their doctor. This analysis excludes patients who were under current therapy for anaemia of any type.

Question: Would Miss Paterson agree that one of the biggest social problems is that of gambling? Does she think that in view of the turnover in gambling among working class families, the Government should consider closing betting shops?

Miss Paterson: I think this is a cultural matter. The Scots and the Northern Irish are repressed Calvanistic people, who have got to get it out of their system somehow. The rate for alcoholism is bad enough in both countries; what it would be like if you denied people gambling I cannot imagine. Seriously however, I do not approve of free access to gambling shops. On the other hand, it has brought it out into the open and no one knows how much gambling went on before the betting shops were opened. The thing I would like to see stopped is the provision of bingo at every street corner. I do not know whether these things are more or less dangerous than alcohol and smoking. I could not answer the question whether the shops should be shut because I feel that there are more dangerous things than gambling, however distressing and productive of social problems it may be.

Dr J. P. Gallagher (*Glenary*): As regards early diagnosis of psychiatric illness and early diagnosis of social problems, how can a general practitioner get a patient well who receives £10—£15 a week more for industrial injuries than he does when he works?

Miss Paterson: You have to change the law so that there is really no deterrent for a patient returning to work before he is pronounced cured.

Where I come from, the disablement officers make a great feature of this. They say that the great thing is to get the person interested in rehabilitation and to return to work before he is pronounced fit, but people will not accept it. I think this attitude is due to long experience of the law and giving its consent, which probably goes many, many years back; they have heard all about it from their fathers and grandfathers. You have to stress the fact that you are a doctor, and what you say goes. There are times when you have to do this and tell the patient that it is going to benefit him very much to return to work and exercise his limbs.

Dr H. Nelson (*Co. Tyrone*): In my opinion because of modern architecture the home and the family have been fighting a losing battle. Many council houses are so constructed that there is only one room in which the whole family must sit, eat, talk, and live: where schoolchildren can find neither peace nor place to do their homework. The younger members of the family are deprived of the human warmth and affection they expect from their mother, so the whole family grows up shy and artful, with wounded souls longing for some way of attracting attention. Thus adult delinquency in the form of antisocial behaviour is nothing other than a rebellion against environment. Dr Grant asks us what *we* can do and suggests that the early diagnosis of psychiatric illness rests with the general practitioner. No one knows the conditions better, with the exception of the district nurse. As a general practitioner, I suggest the following: (1) More women on councils: (2) A better education for architects: (3) More forethought in building homes; to build better homes would be to close prisons.

Dr Elmes: The complete lack of privacy in modern living is important. Open-plan living does not suit everyone.

Dr Carey: One wonders whether the modern standards of housing are as bad as they are painted. If we look at the overcrowding in the slum areas of towns with houses built in the last century, it is clear that conditions were very much worse than they are today; admittedly the council house is designed on a specific size with a specific number of rooms, without very much regard to the family size. There may be a point in encouraging local authorities to build houses which are larger than normal on subsidized schemes.

Dr Grant: One other point which was true of the old-fashioned overcrowded houses was that all the family lived in one room with very little privacy, but in fact each family was so close to the other group of associated families that the children grew up in a tremendous atmosphere of security and a kind of built-in community. This can still be seen sometimes, for example, in studies that have been made on some east London families. When these families are transferred to housing estates, this inter-relationship between families is broken up, and in fact the family is scattered. Sometimes, as was shown in the east London survey, even the families themselves are split up by dividing close relatives and separating them, perhaps by several streets or at least by a garden or two from each other. This creates—and certainly will do for a generation or so—a good deal of

insecurity.

Professor Dick: Well, ladies and gentlemen, it remains for me to thank on your behalf: Miss Paterson, Dr Grant and Dr Carey for three very interesting papers.

Summing up

Professor Pemberton, M.D., F.R.C.P. I am very honoured that the College have asked me to come to this conference and I have enjoyed it very much. I cannot say I am so pleased that they have asked me to do an almost impossible task, that is, to sum up this series of very interesting papers which we have been listening to today.

As an epidemiologist I could tackle this on a purely random basis, picking out points at random from what has been said today and trying to reiterate or illuminate them further. I could take up an equal number of questions from each paper, but I propose to be completely biased, which is the worst mistake an epidemiologist can make, pick out those items which have interested me particularly, and mention a few items which I have called 'matters arising'.

Dr Connolly's paper had some very interesting things in it. I was staggered to know that there are now hundreds of different viruses with many different diseases attached to them. How much more complicated this makes the study of medicine! It was encouraging to know that the influenza detection organization of W.H.O. does enable us to forecast outbreaks of influenza in other parts of the world. Dr Connolly told me that because of this, they have been able to inoculate all the workers of Chemstrand and only had 15 cases of influenza when they might have expected 25 per cent of the staff to go down. That is an encouraging example of prevention in the field of virology. I thought Dr Cardoe's description of rheumatoid arthritis and its protean manifestations was a most fascinating clinical exposition. I was impressed to hear that a careful history and a careful examination are still the best weapons in early diagnosis.

Dr Elmes gave a stimulating address and I was delighted as an epidemiologist to hear once again that he has been very largely converted to epidemiology and preventive medicine. He brought out a good point when he said that sometimes the best way of finding and diagnosing early cases is by an epidemiological survey, because in this way disease is detected before the patient comes. For example, in dust disease due to flax, the man who only gets a little tightness of the chest on Monday mornings never goes to the doctor for that unless he is very neurotic, and yet this reveals the earliest