ance in his life and he can see how health factors are deeply concerned with human relationships. One particular aspect that strikes me as being of peculiar relevance to general practitioners is the changed policy that has been adopted throughout the country and in other parts of the world, with regard to admission and discharge of patients suffering from mental disorders. Many more patients are admitted, which means that general practitioners are spotting patients at an earlier stage. But at the same time many more patients are being discharged who have been in hospital for quite long periods of time; chronic psychotic patients, mostly schizophrenics whose management in the community is a real problem and this is a whole new dimension of psychiatric problems that general practitioners are facing at the present time. This I think is the part of psychiatry which is bringing psychiatrists and general practitioners together, sometimes in not very favourable circumstances, for instance when patients are discharged whom it is thought should not be, and burdens are carried by general practitioners that many people feel should not be carried.

The trends in medical care generally and the trend in medical education seems to bring psychiatrists and general practitioners very much closer together. I suppose that if we are really going to develop further in this partnership, one thing we ought to try and do is to speak each other's language and perhaps this symposium will be a good way of contributing to understanding of basic English that is so necessary when we are talking about psychiatric problems. Psychiatrists and psychologists can be too addicted to jargon; they consider it good for status because by using long words that no one understands they hope that a few people will believe that they know more than they do. There is a technical problem here that has not so much to do with identifying well-known types of disease like schizophrenia, manic-depressive psychosis, or anxiety neurosis—any intelligent doctor can learn that language by just looking up a textbook and attending a few lectures—as with the general field of psychological interaction between the individual and his environment; it is here that we need a common language. Psychiatrists ought to be the first to get down from their high horses and listen patiently to general practitioners who almost certainly have a better working language about these things. I believe they should get together and gradually build up a more systematic language that can allow us to develop this whole field along more scientific lines.

Dr Fraser, along with his four colleagues in a group practice in Aberdeen has made a special study of psychiatric disorders in a large group practice and he is going to tell us something about his experience in this practice.

Psychiatry and the general practitioner

Dr A. G. Fraser, M.B., Ch.B., D.Obst.R.C.O.G. (*general practitioner, Aberdeen*)

I claim no special expertise in the practice of psychiatry in general practice. However, experience teaches fools and I confess to having had over 20 years' experience in general practice. The rôle of the general practitioner is to deal with the patient as an individual and to offer the comprehensive approach of sympathy, understanding and reassurance along with the application of his medical skills, perhaps in that order of importance. Twenty-five years ago as a student, psychological medicine appeared to be something of a poor relation. We had exhibited to us the more severe psychotics who were of interest but presented no problems of diagnosis or disposal; we lacked an

appreciation of the more subtle problems of the neuroses and the many manifestations of depression. This, of course, was an ebullient and materialistic era in medicine, for surgery was making exciting advances and clinical medicine had in its armoury the new specific drugs with which to deal with many infections. As students we had little contact with patients who were not hospitalized, we had yet to find our yardstick of normality, a range of normal behaviour most difficult to define and founded largely on experience. Perhaps this resulted in a tendency to play the rôle of psychiatry in a minor key.

In the pre-Freudian days of the late eighteenth century, the Paris physician Phillipe Pinel was revolutionary in introducing a humanitarian approach in unchaining his patients and forbidding violence in the treatment of the mentally sick. As Stafford Clark put it, "it was this era in France when Pinel and Esquirol indicated real concern for the patient as an individual". This attitude is indispensable to what we now regard as the theory and practice of psychiatry. It was the advent of Freud and others who established it as an important discipline in medicine.

Anxiety and depression are natural phenomena experienced by us all. It is common knowledge that the stress of examinations may cause emotional instability and occasionally physical accompaniments of anorexia, dyspepsia and diarrhoea. So normality is a fairly broad band in the spectrum of behaviour and a doctor's dilemma is often to define the anxiety that falls outside this band and which is out of proportion to its cause. In practice we have all experienced the situation where the patient's anxiety has provoked an inter-reaction within the household, sometimes involving the doctor himself. If the problem is not appreciated, the patient's anxiety may further increase so that a chronic anxiety situation results in which the patient is abnormally sensitive to ordinary stress. This may progress in time to a depressive state. As Myers has said, "in the first half of life anxiety is more common than depression and in the second half of life depression is more common than anxiety and those with a chronic anxiety state often end up as depressives". When the neurotic presents himself, even though one may have known the patient for years, an authoritative approach is rarely successful. It is important at the outset to listen to the patient with his problem, and to examine him properly. If this is borne in mind when the patient first presents with manifestations of a neurosis he has a better chance of understanding and coping with his problem and accepting the doctor's advice. For the doctor it may well mean the saving of many hours of consultation over the years, prescribing drugs for the relief of presenting symptoms. Appropriate drug therapy should reinforce treatment, not replace it. In this way we may prevent an anxiety chain-reaction within the family group and an extension of the patient's anxiety to a chronic condition going on to a severe depression with its more sinister implications. Ours is a northern group practice of 10,000 patients, largely working class, spread widely over the city of Aberdeen, and run by five doctors in partnership. We have an ancillary help, two health visitors and a district nurse; they are of considerable help with the sociomedical problems, and often elicit facts of which the doctor is unaware.

In 1966, the number of consultations per four-weekly period ranged from 2,100 to 2,600, showing little sign of the seasonal variations we used to experience 10 to 15 years ago. For example in the mid-summer months we are just a little less busy than in the winter time. We have estimated the organic disorders at round about 40 per cent of the patients that we see, which leaves the remaining 60 per cent as psychiatric and sociomedical problems. Those strictly of a psychiatric nature and whom we refer for psychiatric opinion average six per month, a small proportion (0.24 per cent) of the patients seen. The delay between psychiatric referral and the first interview varies with the type of referral. Patients are admitted directly to hospital, and domiciliary visits are done within two days. Emergencies are notified by 'phone directly to the psychiatric department, and dealt with the same or the following day. The co-operation here is excellent.

On the other side of the coin, 62 per cent of patients had to wait between eight and 21 days. This is comparable to some other specialties and better than some, but it is sometimes difficult to persuade the patient to accept the idea of being referred to the psychiatrist and the longer they have to wait, the more their resolve to attend hospital weakens.

Divorcees have the highest referral rate, followed closely by the widowed and then the single person. A number of the widows, several are over the age of 75, are suffering from senile dementia.

The commonest psychiatric diagnosis is neurotic depression, followed by the psychopaths, the antisocial, the aggressors, the immature, the inadequate and the paranoid. These are mainly in the younger age-group and one might say that psychopaths, like wine, improve with age—with the possible exception of the paranoid type, the majority of whom were females. In a two-year period we had only two cases of schizophrenia and two of alcoholism; though these are serious continuing problems and difficult to manage, they are not common in our practice.

In studying psychiatric referrals, we found wide variations between partners. It may well be that the patient with a psychiatric problem is likely to go to the grey-haired devil that he knows rather than the younger one that he does not know. The background may be relevant. Dr A had some postgraduate psychiatric experience dealing with the resettlement of repatriated prisoners of war, both European and Japanese, and had attended a fairly recent course in psychiatry. Dr B has attended various psychiatric seminars but had no formal psychiatric training. Dr C, who has been with us 12 years, has referred only eight in two years; she does not want to get involved in psychiatric cases at all and finds herself getting too emotionally involved. Dr D has had experience of the mental disorders of the old in the geriatric wards, while Dr E is the only doctor in the practice with formal psychiatric training, having spent six months as a house officer at the Ross Clinic in Aberdeen. She referred only five patients in two years of whom three were senile dementias which posed no problem of diagnosis. She is the youngest partner and it may be she sees fewer psychiatric cases but it is more probable that she is dealing with some cases herself which the other partners are referring.

I would now like to discuss the problem of diagnosis and management in the 60 per cent of patients, with minor psychiatric and sociomedical problems. The doctor may be in some doubt as to whether the patient's complaint is wholly somatic or due to a psychogenic condition presenting with somatic symptoms. It may be apposite here to note the aphorism of a consultant physician, that he never makes a diagnosis of depression or anxiety state without first doing the erythrocyte sedimentation rate—and a physical examination does not come amiss. The family doctor has a choice of three lines of approach to this problem; referral, symptomatic treatment, and adequate management.

In the first place, the general practitioner may refer the patient for consultant opinion on the presence or absence of organic disease. When the consultant finds no evidence of organic disease he quite rightly refers the patient back to the general practitioner. But what does the general practitioner do now? The manipulating patient may present with a changing symptomatology and persuade the doctor to refer him to another specialty. If this course is pursued repeatedly with disinterest by the doctor there is a distinct possibility of creating a 'fat file' syndrome, in which the patient's record envelope becomes filled with reports from various consultants in various specialties. Only after successive negative findings over many years are these persistent cases suspected of having an underlying psychiatric condition, this is a train of events leading to a chronic problem with an iatrogenic component. In both the patient's and the doctor's interest it should be avoided.

A second course open to the doctor is to start treating the patient empirically with

drugs, so that the symptoms are treated and not the disease. We should avoid unnecessary and uninterested prescribing which may result in drug dependency, both physical and psychiatric. These pitfalls may be avoided by an awareness at an early stage of the possibility of minor, though important, psychiatric illness. Thirdly, there are the many patients we treat ourselves. Some have minor anxiety states and depressions, others the varying sexual problems of incompatibility, impotence and frigidity; and then there are the many sociomedical problems which take up so much time. In the treatment of some of these patients we are aided by the newer, safer and more effective drugs—for example amitriptyline and imipramine in depression and diazepam and similar drugs for anxiety. These are of great help and no doubt enable us to treat patients whom we may otherwise refer for psychiatric opinion. We have almost abandoned the barbiturates and the amphetamine group of drugs; these are potentially dangerous alone or in combination. Certainly, the barbiturates can be lethal in combination with alcohol even in relatively small doses.

With some patients the psychiatric or sociomedical problems will be completely resolved, others will break down from time to time, and quite a few will be our constant companions, supported not so much by drugs as by the availability of the general practitioner himself. First, I should like to say a few words about the all-important patient–doctor relationship. As Balint and others indicate in *The study of doctors*, there is as yet no agreement about the sort of psychiatry needed in general practice. It is salutory to note Balint's observation that not every general practitioner—no matter how successful—is a suitable candidate for training in psychological understanding and psychotherapeutic skill. But then there are many other disciplines in medicine to which a doctor may not be well suited. However, Balint indicates that we should look at ourselves as the other part of the doctor–patient relationship, and he directs the doctor's attention as much to his own personality and idiosyncrasies as to the traditional subject of medicine, the patient. His book describes in great detail the findings of a 14-year postgraduate scheme for general practitioners in the field of psychological medicine, the aim of which was first, to develop perception and sensitivity to patients' emotional problems and second, to help doctors acquire skills in making therapeutic use of this understanding.

The pre-condition for acquisition of this increased sensitivity and therapeutic skill is a general loosening up of a doctor's personality. He must recognize emotional factors in his patient that he rejected or ignored before, and learn to accept them as worthy of his attention. My own belief is that in the diagnosis and treatment of purely somatic complaints—for example, broken bones and surgical emergencies—the personalities of doctor and patient are of little relevance. The patient should improve with specific therapy irrespective of the doctor's approach. However, where the problem is solely or mainly psychiatric, a special doctor–patient relationship must be established.

It has been said that psychotherapy begins when the patient first comes into the consulting room. It may be that some doctors are incapable of entering into the kind of relationship required for psychotherapy; though most will recognize the psychiatric nature of a problem, some may find it difficult to maintain the emotional detachment required for its solution.

It is the unrewarding but necessary burden of the general practitioner to be saddled with the continuing problem of patients for whom formal psychiatric help is unavailing, and for whom the doctor's patience, understanding and experiences are the mainstay and comfort. The practitioner of old had no help from colleagues, but with his knowledge of the family background he could help and perhaps resolve the psychiatric and sociomedical problems of his day with only his common sense and his therapeutic, humanitarian approach.