SECOND SESSION

OPENING REMARKS

Dr Annis Gillie (*President, The Royal College of General Practitioners*) (*Chairman*)

If there is one name that is more closely associated than any other, with psychiatry it is that of Yellowlees and so it is of particular interest to welcome Dr Walter Yellowlees, so well known to everybody here to speak on what one might call his family's traditional discipline and in relation to our own special discipline of general practice.

"All the world's a stage"

Dr W. Yellowlees, M.C., M.B., Ch.B. Edin. (*General practitioner, Aberfeldy*)

If we think of the human psyche as a dynamic thing motivating all human activity, how can we define its limits in our patients? Can we separate off a group of illnesses and say that these are psychiatric or psychogenic as opposed to this other group which is purely organic? I do not think we can. Every illness has an emotional component and the doctor's judgement of what is psychiatric will depend on his awareness of this component and on the importance he attaches to it. Estimates are therefore always bound to vary according to the personality of the observer.

Let me try and illustrate the difficulty by quoting a case; a woman diabetic aged 48 began having a series of devastating hypoglycaemic attacks. On many occasions as she lay deeply comatose on her sitting room carpet, intravenous dextrose solution had to be given before she regained consciousness. She was referred back and forth to hospital departments but adjustment in her insulin regime and diet made no difference; the attacks continued. This seemed at first a straightforward case of unstable diabetes, but the salient fact in the history was that until her recent marriage to a man much older than herself she had held down quite a responsible job, and managed very well. It became increasingly obvious that this marriage was at times far from happy. During my visits violent arguments would flare up between husband and wife, and, as so often happens in general practice, this was a case where you start off with what seems to be a simple complaint and you end up as a kind of unwilling referee in a marital boxing ring. In this bout when with some care the contestants were separated from their clinch and discreetly listened to in their respective corners, her story went something like this. She protested, "Doctor, he nags, nags, nags me about my insulin, about my tests and about my diet, he keeps going on at me, he won't leave me alone, oh if only he would leave me alone". (And I wondered if this was an echo of the age long cry of the frigid wife).

The husband in his corner fancied himself as having some medical knowledge. "Doctor", he would say, "I try to keep her right with her insulin and with her tests and with her diet, but she pays no attention to me, no attention at all, she will just not do what she is told". (A hint, there of the age long exasperation of the husband, going right back to the book of Genesis). I do not pretend to understand the biochemical mechanism in this case, but I am sure that the cause of the trouble was essentially psychiatric and subsequent events proved this assessment to be correct. But if I had not

taken the time to listen I might have missed the important part altogether, and entered this in the organic file.

To take time to listen is exacting but he who does so is rewarded by a glimpse into that vast underworld of the dynamics of human emotions, a world of ever-continuing drama, how profoundly true then that "All the world's a stage and all the men and women merely players".

Of all those privileged to hold a medical degree, we in general practice have the best view of this kind of stage, we have the best seats right down in the front stalls. More than that, as our patients act out their particular little drama we are frequently called on to the stage to play a part, sometimes we are even invited backstage where we see the players without their make-up and without their masks. How do we make our intervention on the stage in such a way that it is therapeutic—this is what I now want to discuss. I have made out a table in which are noted some of the factors which in my opinion make or mar our intervention. I used the word healing rather than therapy, therapy suggests something active which the doctor does to the patient whereas healing implies that the doctor's rôle is more like that of a catalyst through which the patient finds his own way back to health.

HEALING

FOR	AGAINST
Doctor's insight and attitude	Lack of time
Long interview	Doctor–patient hostility (?N.H.S.)
Drugs	Investigation roundabout
Placebo	Small community
Hypnosis	Placebo
Sense of humour	Drugs

Let's begin with the 'for' column.

Insight and attitude—on this all else depends. Our insight must cover not only our patient's feelings but also our own, we must try and understand what the patient is doing to us for all doctor–patient contacts involve a two-way exchange of feeling. Our attitude is of the utmost importance. It will make or mar whatever other form of therapy we may try; how to develop and foster this insight should be one of the major tasks facing a reformed training programme for general practice. Dr Balint has discussed in one of his books[1] the considerable, though limited change in personality required to enable a general practitioner to undertake the task of therapeutic listening. His Tavistock Clinic seminars surely point the way to what might happen up and down the country where psychiatrist and general practitioner sit down together not in the rôle of teacher and pupil but rather as equals exploring this vast territory. There is a difficulty though: Balint and his colleagues[2] have estimated that the proportion of general practitioners who would find the Tavistock Clinic scheme acceptable is only some 50 to 60 per cent. Does this imply that almost half of our general practitioners are not equipped by nature to come to some kind of deeper understanding of themselves and of their patients? If it does, and if we remember that many patients however understanding the doctor or, for that matter, however skilful the psychiatrist, are unwilling to face their own emotional difficulties and would rather cling to their symptoms, we must conclude that in this imperfect world the quantity of healing is strictly rationed.

The long interview—This is a deliberate decision to get involved in the drama and to accept the wide variety of rôles which may be thrust on us by our patients. In taking this decision we must not be too elated if we are cast in the rôle of hero, nor too depressed if we find ourselves the villain. One rôle which we should avoid, however much our patients want us to accept it, is the rôle of a Jehovah. I have no rules to offer on how

patients should be selected for long interviews; I am guided very unscientifically by hunches. The frankly psychotic and the seriously depressed are quite outside this scheme, and I do not believe that certain so-called stress diseases will be cured by any kind of psychotherapy—for example, peptic ulcer or coronary thrombosis. The important thing in embarking on long interviews is to get hold of the patient's whole situation which may take several sessions. With some patients I return to dry land after one or two interviews, with others I may go on for a number of years. The thing is rather like fly fishing, sometimes it pays to go on doggedly, hoping for a rise; at others it is better to pack up immediately. I am sure that group discussion with a psychiatrist would be of immense help in managing these patients, but for me geographic isolation has made this impossible. Willingness to get involved in this way explains the wide gulf between the consultant and general practitioner. In the case of the diabetic woman I considered my findings so interesting that I wrote to the city consultant who had dealt with this woman before she married and came to our area, but he replied rather shortly advising certain changes in her regime and made no reference at all to the emotional factors.

Consultants who have no experience of continuing contact with families over the years, and who view the stage dimly and from afar, feel rather lost when we try to discuss with them the complexities of the plot.

Drugs—it would be presumptious of me to discuss these at length; Sargant's[3] plea for a mechanistic approach to psychiatric treatment in general teaching-hospitals may be valid for the hospital world, but in general practice while we must do our best to keep in step with the pharmacological revolution which has undoubtedly transformed treatment of many psychiatric conditions, we must remember that our main weapon is not drugs but ourselves, our insight and how we intervene. In general practice drugs can be of tremendous value, but I doubt if they can ever replace the personality of the doctor, for this reason I have put drugs in both 'for' and 'against' columns, where they are used as an excuse to side-step the real problem they go against healing, and this too applies to placebo.

I will now discuss the 'against' column. These factors are formidable. Lack of time heads my list, the use of time in general practice would be a good subject for a symposium. I liked a letter which appeared some years ago in the *British Medical Journal* which said that no business-efficiency experts would be able to complete a survey of general practice, because before they got very far they would die of laughter. Maybe now that the lunacy of the pool system of payment is behind us, things are getting better, I repeatedly vow that because of lack of time I cannot possibly go on attempting psychotherapy, but no sooner have I made this resolution than a patient appears for whom any other course would seem to be running away and so I soldier on as best I can.

Doctor–patient hostility. This is terribly important and the best way I can describe what I mean by this term is by telling of an incident which happened a couple of years ago. One Saturday night I had a harrowing confinement, post-partum haemorrhage 30 miles from the nearest source of blood, always an anxious business. I had about one hour in bed and with dawn on Sunday I hoped for some sleep but a woman 'phoned and insisted that I go and see her husband who lived some six miles away. I tried to put her off by saying I would come the next day, I was very busy and so forth, but she would not be put off, so I went. All of you must know that terrible feeling as you drive along when it really takes an effort of the will to keep your eyes open, and when I arrived, this chap was sitting up in bed with every sign of ease and comfort. Sunday papers were strewn over the covers and a pile of fag-ends was beside his bed. When I asked him what the trouble was, with a silly grin on his face he said he was feeling tired. He did not want diagnosis or treatment, all he wanted was to impress his employer with whom he had been having a row. Patients of this type form a small minority in every practice, immature, inadequate personalities whose infantile reaction to any kind of difficulty is to lie back and bellyache

until the doctor comes running. They may form an interesting subject for study from the safety of a university department, but when in the turmoil of practice they repeatedly come between you and your food or your sleep, a detached viewpoint is not easy. Intervention is not likely to be therapeutic when you are uncomfortably aware of the strong desire to give the patient a sharp bash over the head.

In my scheme I have indicated that some of our hostility spills over to the National Health Service, the system which at times does seem to encourage these inadequate people to adopt an infantile attitude. Does the N.H.S. positively retard the growth and maturity of a small section of the community? I doubt it, and to be fair to the service it has allowed our access to emotional problems which patients might otherwise have kept to themselves.

The investigation round-about. I have used this phrase to describe the situation where a patient goes round and round hospital departments achieving nothing but the acquisition of a bulging record envelope and a string of meaningless diagnostic tags.

Let me try and illustrate this. An unmarried woman, aged 38, went for a cone biopsy following a suspicious cervical smear. On the day she returned from hospital I was sent for. She was in bed and her mother with whom she lived was in the room; from the expression on both faces I sensed a certain air of drama. "Doctor", she said, "I have got a deformed back". Now, this was news to me and on further enquiry the course of events appeared to have been something like this; one of her complaints had been backache, and with commendable thoroughness, the gynaecologist had arranged an x-ray. The report had stated that there was spondylolisthesis at the lumbosacral junction with neural arch defect of L5. On receipt of this one of the junior staff had come triumphantly to her bed to give her the glad tidings of her deformed back. She was sent to an orthopaedic clinic where a corset was prescribed and she was given an appointment to return in a few weeks. Now here was a patient mounting the roundabout. As her backache got worse, and I was fairly certain that it would get worse, I could foresee the endless revolutions in front of her, manipulation, intravenous pyelograms, back to the gynaecologist, round and round. I knew she was ripe for the roundabout because her situation was not very happy. Seventeen years before I had attended her when she gave birth to an illegitimate son, at which time she said the father had let her down, and I think she was correct. It had been her only excursion into heterosexual relationships and she lived on with her mother and the boy. He had recently been in trouble with the police for delinquent behaviour and this was causing her great anxiety, her job was boring and she was completely fed up. She was at a point in her life when she dimly realized that she had missed a lot of what life had to offer, so I wrote to the orthopaedic unit and cancelled her follow-up, although she declared repeatedly that her back was 'killing her'. We waited expectantly for the corset—they take ages to arrive—and all this time she was off work, still saying her back was killing her. The week following the arrival of the corset when she came round for a certificate, she declared that the *corset* was killing her. This I felt was an advance, you can always throw away a corset that is killing you. So we continued to discuss her problems; she decided to go away for a while hoping to get a new job, but she returned after three weeks having decided she might as well carry on her old job, where she has remained more or less contentedly since. If we have sufficient confidence in our assessment it is our duty to haul our patient off the roundabout even if it means arbitrarily cancelling hospital appointments. This decision involves all that we know of the art and science of doctoring. If we make a mistake, we will incur tremendous odium from colleagues and patients alike. But our fears of missing organic disease condemn thousands of patients to wasted years on the roundabout and to the organization of their illness around some irrelevant minor abnormality. The conviction that the thing must be organic comes very easily of course to graduates schooled only in the hospital environment. I hope that in the not too distant future all undergraduates

by systematic exposure to general practice will learn something of the hidden language of symptomatology—of the way the human drama may be acted out.

Small community. This is a problem peculiar to my situation; there are difficulties in attempting psychotherapy in a small place where the community life has a distinctly introspective flavour. Patients may be more resistant to discussing the intimacies of their lives if they know that they might meet you next day in the street or if they realize that the neighbours know that they are going regularly to the doctor. These difficulties do not loom so large in the more impersonal setting of an urban practice.

These then are some of the factors which in my opinion may hinder or help us in our rôle as healer, I am sorry I have no time to discuss hypnosis or the importance of a sense of humour. The Act of 1948 mentions prevention before cure, and I am surprised that so far no one has mentioned the prevention of neurotic illness. Are we succeeding in this primary task of prevention? Is neurotic illness in all its manifestations less than it was almost 20 years ago when Aneurin Bevan launched us on our way?

I think it was Dr T. A. Ross who discussed in one of his books the observation that in the First World War the rate of neurotic breakdown among soldiers was far less when the army was advancing than when it was static or in retreat. This may have no relevance to civilian practice at all, but it is interesting to ask: How is our morale in 1967, are we advancing? As has already been mentioned there is enormous difficulty in assessing any trends owing to the difference in observer bias. Certain statistics do appear to indicate that in spite of the enormous material advances of our present society, our ability as a nation to make satisfactory relationships with ourselves and with our neighbours may not be improving. Over the last decade there has been a steady increase in the number of divorces, in 1965 for marriages originating in Scotland the number of divorces (2,456) was a new record and this trend continues. Where there are children each of these is a potential focus for disturbance among a large number of people. Crime statistics show a record high, it would seem that over the last few years in Scotland there has been an annual increase in crime of between three and four per cent, the same figure as the Government's target for the annual increase in productivity! Over the last decade, membership of the Church of Scotland has fallen by 85,766 to a record low figure. The proponents of the Post-Christian Society and its new morality would regard this as being a sign of increasing mental health, for has not one of their own prophets declared that all religion is a childish illusion. Whether these statistics of trends in divorce, crime and church membership have any significance in relation to psychiatric illness I do not know, but I am quite sure that on a personal level the amount of neurotic illness will always depend on the integrity of the biological unit of society, the family, and maybe on a national level on this ill-defined quality, morale, this dimly felt awareness of whether as a nation we are advancing, static or in retreat. On a personal level general practitioners can play some part in prevention; every patient who is pulled off the roundabout and helped to face his personal problems is a blow struck for prevention. Doctors, by sympathetic understanding, can do a tremendous amount in family life in those crises of birth, death, adolescence, to prevent neurotic breakdown. But how little we know of what is the best matrix for the healthy growth of this biological unit, the family. We need far more study of this question, and what a tragedy that that splendid laboratory set up for this very purpose, the Pioneer Health Centre at Peckham[4] was allowed to die for want of funds.

As a bigotted countryman I view with dismay government policies serving exclusively an industrial economy, policies which are daily losing us not only fertile land, which in the hungry years ahead we will surely need, but as the pace of rural depopulation quickens we are destroying country-bred human material which if present trends continue will soon be extinct.

These thoughts and the title I have chosen brought to my mind a final little scene,

if I may get back to my stage. On the stage of Christendom, in seeking guidance to these profound problems of personal and national life which I mentioned so briefly, the people traditionally put at the centre of their stage, the man of God, the preacher in his pulpit. Even if both preacher and audience failed hopelessly down the centuries to live up to the message that was preached, nonetheless in all walks of life formal recognition was given to an optimistic divine purpose and to the active presence of the devil. But over the last 200 years the audience has become increasingly bored with this kind of sermon, and the reason for their distraction has been the dramatic entry of a flamboyant character, the wizard. In the *dramatis personae* of this fantasia the wizard is described as a "technocrat or technologist who believes in human salvation through scientific and industrial advancement: despises the preacher". The wizard's performance has been impressive and he deserves the thunderous applause he has been given as act follows act, moon rockets and monoamine oxidase inhibitors, atomic fission and television, jet propulsion and juke boxes, computers and contraceptive pills, no wonder the preacher has forgotten his words, but the wizard has become so pleased with himself —he knows not the meaning of the word humility, and is a chap of endless conceit— that he has pushed the preacher into the wings, put on his robes, mounted the pulpit and started preaching sermons. I am sad to note that sometimes our later-day psychiatrists are not loathe to play the wizard in the pulpit. Now a pulpit is no place for a wizard, and his elevation there is a dangerous thing, dangerous because his sermon is based on a rather nebulous Freudian doctrine that the chief end of man is the pursuit of personal wealth and pleasure and touches not at all on the inescapable knowledge of good and evil. I make no apology for raising these issues, they cannot be ignored in any discussion on the prevention of neurotic breakdown, and I end by suggesting that if we are to look forward to a society which has stability and purpose, and therefore mental health, we must think seriously of putting the wizard in his proper place before the curtain is run down in chaos and darkness.

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Some concepts of domiciliary psychiatric practice

Dr J. G. Henderson, M.B., Ch.B., Dip. Psych. (*Consultant psychiatrist, Ross Clinic, Aberdeen*)

Visiting patients in their homes is a tradition of British medicine, of particular relevance to general practice, with its accent on the family physician and the holistic approach to the patient. For many medical generations it has been the custom to invite the specialist to visit the home, consult, and distil the recommendations for treatment. It is understood that awareness of the emotional needs of patients is important in any doctor–patient relationship and it is paramount in the field of psychiatric medicine. The literature on domiciliary psychiatry is still sparse, but American sources have begun to examine the home visit in the setting of private psychiatric practice, and also to con-