Was drink taken:

(*a*) For its effect?	6
(*b*) For its taste?	1
(*c*) Both?	3

Was oblivion the desired end-product?

Yes	5
No	3
Don't know	2

Drinking patterns:

1. (*a*) Solitary	2	2. (*a*) Continuous drinking	4
(*b*) Convivial	0	(*b*) Bout drinking	2
(*a*) Following (*b*)	3	(*b*) Following (*a*)	3
(*a*) and (*b*)	5	Could not say	1

	Yes	No
Were drugs taken also?	—	10
Trouble with law, police, authorities?	4	6
Suicide ever contemplated?	7	3
Did blackouts occur?	6	4
Was food neglected?	7	3

Note:—Eight out of the ten stressed the difficulty of regaining self respect and facing up to their fellow human beings.

Discussion

Dr Reid (*Auchterarder*): I should like to ask Dr Yellowlees about his leading lady—his unstable diabetic with marital stress. Was she stabilized by psychotherapy, or by the chilly advice of the physician to re-adjust her insulin, or does the instability still prevail?

Dr Yellowlees: She was stabilized by the death of her husband. The poor man had a series of cerebrovascular accidents and eventually passed out with a coronary, and I was sure the lady would be all right, which indeed happened. She became much more stable until one day about two or three months after her husband's death when she suddenly went off into a deep coma. I discussed this with her and she said, "I have just heard that some of my husband's relatives are coming to visit me".

Dr Forth (*Cromarty*): What would be the feeling of the consultants regarding the possibilities of consultant–general-practitioner discussion groups, where the general practitioner could gain insight into his own handling of certain patients' situations? I understand that within hospital practice this is almost routine.

Dr Henderson: Yes, indeed; I would actively encourage this. We certainly do it routinely in hospital, at case conferences, and by encouraging the most junior house physician in psychiatry to disagree with his consultant. This is something that is not accepted in many branches of medicine, but the junior man's opinion about an interpersonal situation is just as important and perhaps more valid at times than the consultant's. I would be strongly in favour of any family physician wishing to take part in this kind of group discussion, and I am sure that I speak for my colleagues by saying that, if a group wished to establish itself, we would be very interested to hear of it.

Dr Patterson (*Edinburgh*): For two years recently I attended a once-weekly Tavistock Clinic-

type seminar. We discussed approximately 60 cases and at our most optimistic, thought we had perhaps achieved one cure. Did this result justify the expenditure of approximately 1,000 general-practitioner hours and 60 psychiatrist hours?

Dr Henderson: If I was to try and make a question out of this it would be: What is a cure worth? I would rather re-phrase this as: What is a change worth? If we are thinking in terms of the effect of medicine generally and the number of patients we cure, then we 'waste' a great deal of time. But if we mean that perhaps some subtle change takes place, which may not express itself today or next week, but perhaps next year, then I think that the hours spent are worthwhile. I wonder if the doctor in question is perhaps expressing a little unease at the rather academic discussion of interpersonal relationships which can arise in such group settings.

Dr McGlone: Do not treatment in hospital and other attempts at treatment often delay the arrival of the alcoholic at the point of decision?

Dr Whittet: I think this is an excellent question because as Alcoholics Anonymous point out, each alcoholic must help himself before he starts on the road back. It is the duty of any consultant who is called in to give advice, to emphasize this point.

Dr McGlone: My view is that drug therapy should not be given and I withhold it entirely in the case of alcoholics, on the basis that I am simply delaying the point of arrival at decision by making things comfortable for the time being. I would like to have your views on that.

Dr Whittet: I would agree, because with modern treatment we sometimes substitute one poison for another. I think we are right to use drugs within limits to get the patient over the acute stage. It will never be easy for the alcoholics because they have to face up to beating this addiction.

Dr Fraser (*Bucksburn*): Which would you rather have, an alcohol addict or a marihuana addict?

Dr Whittet: I have no doubt that there is something more natural in this country about addiction to alcohol. In Scotland the drug addicts are on the fringe of society. I examined a membership candidate from Cairo, during the recent war out there, who looked a bit sorry for himself, so I thought I would make him feel at home. Since I could not ask him about alcohol, I enquired about marihuana. His face lit up, he smiled and said, "Oh, that is the trouble in our country and it's a most serious problem, the Government are worried about it, there is legislation about it on a very big scale because, don't believe what they say doctor, people do degenerate, they become down-and-out and that causes a lot of suffering." Then I asked, "What about the drug-pushers, what do you do with them?" He said, "Oh, doctor, it's simple, we shoot them."

Dr Yellowlees: I would like to ask Dr Whittet what he would do as a general practitioner if a family had an alcoholic member who would not come for help, but the other members of the family urged the doctor to do something about it.

Dr Shearer (*Bucksburn*): Is the panel in favour of compulsory certification of alcoholics for treatment purposes?

Dr Whittet: This has exercised the minds of much more distinguished people than myself. I think I am right in saying that the consensus of opinion in this country is that we are against special forms of certification for alcoholics. Eire tried it and failed. Very few families wanted to certify a relative as an alcoholic, though quite willing to certify somebody who was mentally ill and in need of care and treatment. It remains in this country one of these curious things which I think involves not only the British genius but the Scottish genius, for not laying down the law too tightly and leaving it open for individual discretion. Alcoholics can sometimes be reckoned as certifiable and put in on an emergency if it warrants it, and detained even longer at other times when another alcoholic in slightly differing circumstances would not be so regarded. One of the hardest things in our branch of medicine apart I think from estimating potential risk of suicide or murder is really knowing when to step into the family situation with an alcoholic who may well be a friend, and the family very friendly. It is terribly difficult and always upsets one, but I confess to writing an emergency certificate very recently under these conditions; it had to be done.

Dr Robertson (*Leven, Fife*): Physicians and surgeons like the general practitioner to be present at domiciliary visits, but psychiatrists apparently prefer to be alone.

Dr Henderson: I can only comment from my own wishes and preferences in this matter. I certainly do not like to be alone all the time. I think that it is important in psychiatry to be put on to the proper lines by the family physician because you can get easily side-tracked. I think it is also important for the patient to be able to feel that they can say things to an outsider that they would not have the courage or that they may be slightly embarrassed to say to their family physician. After all, I am a ship that passes in the night, whereas the family physician is with them always. They may say things to me that they know will be forgotten and are of no importance, but things that both the patient and the family physician will remember afterwards. Another point is that it may sometimes be necessary to allow the patient to express feelings and emotions that he would not declare in the presence of the family physician. Emotions such as hate or annoyance, or highly confidential material may be given on their background or on certain emotionally laden events, such as illegitimacy. Such things may be known to the family physician but a cover has been put on them. I like the family physician to be present because after all he is the host and I am the guest, but there are times when it is necessary to have a word with the patient alone.

From the legal point of view, it is interesting to note, that until the Mental Health Act (Scotland) 1960 it was an offence to deprive anyone of their liberty by carrying out an examination with a doctor present: You had to 'certify' that you had examined separately and apart from any other physician. Nowadays, much more sensibly, you can examine the patient together.