THIRD SESSION

OPENING REMARKS

Dr Annis Gillie (*President of the Royal College of General Practitioners*)

Ladies and gentlemen, here we come to the final session of this extraordinarily interesting symposium. I am going to hand over to Dr Barton who is a generous friend to the College, visiting faculties and always making a great contribution to the value of symposia.

Commonsense, Science and Psychiatry

Dr Russell Barton, M.B., M.R.C.P., D.P.H. (*Severalls Hospital, Colchester, Essex*)

Dr Barton presented his paper.

Discussion

Dr Mackie (*Oldmeldrum*): They say psychotherapy is like confession. Can Dr Henderson tell us of any difference in the psychoneurosis rates of Roman Catholics and other denominations? How far are we invading the territory of the minister in the minor psychoneurotic states?

Dr Henderson: There are interesting variations concerning the incidence of psychiatric disturbances among various religious groups. As I see it, the rôle of the psychiatrist and the rôle of the minister are complementary. I welcome ministers who wish to discuss the problems they have with members of their flock. The short answer is that I do not think we interefere with religion; we certainly respect and invite the advice and skills of the ministries.

Dr D. D. B. MacKellar (*Dumbarton*): In order to prevent alcoholism, what attitudes to drinking would you try and instil in young people—for example, total abstinence or moderate drinking, as (*a*) a parent, (*b*) their general practitioner, (*c*) their youth club leader, (*d*) their clergyman?

Dr Whittet: I think I am old-fashioned. I think that parents shirk too many responsibilities or are encouraged to do so by other people. I feel that teaching about alcoholism must begin in the home. When considered to be old enough, children should be introduced to a glass of wine or sherry on an appropriate occasion. At the same time, and many parents can do it skilfully, introduce the element of warning about excess, about dangers other than complete alcoholism. I myself think that this is perhaps the only way in which it can be effectively done, reinforced by precept and example from the parents. The best way to produce children who are alcoholics is to have a home where there is an attitude of bigoted teetotalism on the one hand, or alcohol flowing like water on the other.

***Chairman*:** Enjoyment, appreciation and knowledge about wine long preceding introduction to spirits is a fascinating thing for a parent to share with children, and I always delude myself into believing that it is a good safeguard too.

Dr Dalgetty (*Edinburgh*): The N.H.S. factor in the doctor–patient relationship is said to engender antagonism, is this doctor–patient or patient–doctor antagonism?

Dr Yellowlees: Patients often wish their practitioner to play the part they want him to, often motivated by their own unconscious wishes, one rôle which they will want him to play is that of an inferior person, I am thinking of the upper classes in my own practice who will come in and say, "I want to see a specialist", and they seem to get a certain amount of satisfaction out of making you feel rather small. Patients like that have a lot of hostility and they express it towards their doctor. The amount of hostility a doctor will have towards his own patients depends I suppose on this personality change that I talked about, but he really should have no feelings of hostility towards his patient at all. If he is paid a few guineas for each consultation he will have much less hostility for his patient and one cannot altogether leave the National Health Service out of it: some of the great trials and tribulations which patients cause for the doctor are due to the present set-up. Another factor is the danger that if we are setting up over-large health centres, we begin to think of the patients as someone 'over there' with a certain air of hostility. There is a widening gap between doctor and patient in a big unit which brings in some of the atmosphere of the large outpatient department.

Dr McGlone: Would you agree that one of the most effective sustaining therapeutic influences for alcoholics is other recovered alcoholics through the medium of Alcoholics Anonymous?

Dr Whittet: I do agree, absolutely. One of the most interesting things to see is how a recovered alcoholic takes an interest in other alcoholics, and he usually does it pretty well. It helps them to get back their self respect which, so they tell me, is the most difficult thing for them to do. However much they may try to hide it from us doctors, and their relatives, it is getting back self-respect within themselves that is really the battle. Helping others is probably the quickest way to enable them to do this.

Dr Yellowlees: Is it generally accepted that the prognosis for a female alcoholic is much worse than for a male alcoholic. Is this really the case? Have you ever known a female alcoholic that got better?

Dr Whittet: I think the popular view is that it is far worse for a lady to be an alcoholic than for a man, and somehow we grew up with this, rightly or wrongly. Of the series that I mentioned two of the ten were in fact ladies who have recovered, if that is the right word, for quite a number of years. I think that in general we have assumed that it is more difficult to cure female alcoholics. Whether it is that until the last few years, there have not been so many, and therefore we have not known about the problem properly, I do not know. Our knowledge is far from perfect.

***Chairman*:** May I suggest a different reaction between men and women, to myself as a doctor anyway. The men did rather well and they seemed to like the feeling that 'mum' said they were doing well and even pushing them hard; the women did very badly and assumed that I was judging them. The two were quite distinct and the sooner one recognized it and tried to adjust to these differences the better. The reasons why men seek women doctors are curious and interesting in themselves.

Dr Whittet: Many people believe that mind and body are so related that there is a mixture to make any depression—part endogenous part reactive. You are dealing with a human being where mind and body are inter-acting. This old-fashioned view is upheld by Sir Aubrey Lewis in his famous *Treatise on melancholia* and there have been conflicting opinions, even in our own hospital. Two of us believe that you cannot separate them, one of the others that you can draw a rigid line.

Dr Barton: Would you use monoamine oxidase inhibitors as a treatment?

Dr Whittet: The switching over is difficult, we have not been sure of the cause of one or two very nasty reactions in the past. To be honest, on the whole we tend to avoid them now, I do not know if this is general.

Dr Henderson: One point I feel I may make on drug therapy is that there are certain patients who have only one aim in life and that is to end the misery as soon as possible. These people

should be given the benefit of electroconvulsive therapy immediately. The moment you give monoamine oxidase inhibitors you have put the brakes on your own car, because if it goes wrong, no other drug can be given for about 10–14 days, whereas if you start with anti-depressant therapy by imipramine or amitriptyline, treatment remains a matter of personal choice and idiosyncrasy. If you start them off on any of the thymolectic drugs apart from monoamine oxidase inhibitors you have this freedom. A depressed person on a Monday may not be a serious risk, a depressed person on a Thursday may be a suicidal risk and I think you have to watch the spectrum of change in depression.

Dr Stewart: I would like to ask whether there is approval for the question which is now apearing on some life insurance examination forms—"Has the patient consulted a psychiatrist?", —because this can obviously be held as an adverse factor on whether they are accepted or not. Should this influence us when we decide whether or not to send a patient to a psychiatrist?

Dr Henderson: Why as a profession do we go along with the form with which we do not agree? I think that every doctor should use his own discretion in this matter. You have to use your professional conscience in this and decide whether you are going to leave the space blank or exactly what you *are* going to do. I think it is a question of being relatively honest. There is nothing to say that you *have* to fill in this particular part of the form. Many a young person has seen a psychiatrist for some particular reason and is not insane, or of unsound mind, or inadequate or anything else, he simply has to see a psychiatrist. A number of countries are very chary indeed about accepting patients who have had any form or stigma of contact or association with psychiatric services. When such a problem is put forward to me, I go over their record very carefully indeed and if I feel in my inner conscience that this is a passing psychiatric disorder, I will answer accordingly. At the same time I think that if a person clearly has a recurrent serious illness, clearly may be a liability to himself, irrespective of the insurance policy, irrespective of the country he is trying to emigrate to, I think we must be equally accurate and honest. It is a similar problem with the epileptic and a driving licence, and that has caused a lot of argument.

VOTE OF THANKS

Dr I. M. Scott: On behalf of the audience I would like to thank the Chairmen, Dr Annis Gillie and Professor Millar, also Messrs. Geigy (U.K.) Limited, Pharmaceuticals Division, without whom the symposium would not have been possible. While thanking everybody I must mention particularly the tremendous amount of work put in by Dr David Fraser.