YORK ORATION

The blue plague*

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WHY have I chosen as the title of my talk "*The blue plague*"? Mr Macmillan, when Prime Minister, told us that the man in the street had "never had it so good," and yet side by side with great material prosperity, and with a vastly improved standard of health, there are signs that we live in an unhappy and insecure society.

Suicide

The evidence includes a high suicide rate. It is falling through better hospital services and the Samaritan organisation, but it is still too high. Material prosperity and fame do not ensure happiness. Pop stars like Jimmy Hendrix and Brian Jones died at an early age from drug overdose. Marilyn Monro killed herself, as did Tony Hancock, one of the best comedians of our time. Such actions can set a macabre fashion. When Michael Aspel, the newscaster, was asked by some school children, what was the most exciting news flash he had ever had to announce, his reply was that he was most moved emotionally when he had to broadcast the news of the death of Marilyn Monro.

Medical men are not immune; psychiatrists themselves are more vulnerable than most.

Self Poisoning

The successful suicides are, however, only the peak of the iceberg; there is a veritable epidemic of self poisoning. Henry Matthew (1971) in a survey of self poisoning, showed there has been a spectacular rise in the incidence since 1950. Indeed in Leicester it is the commonest cause of medical admission.

Addiction

The third major symptom is a wave of addiction to alcohol and drugs, both hard and soft. Vast numbers are finding comfort in tranquillizers and sedatives which they can acquire from their doctors with the greatest of ease; others buy drugs freely from chemists. There must be very few womens' handbags free of them as pill boxes can be bought in any department store—a silent witness to the vast numbers of tablets carried and consumed. Dunnell (1972) found that on average, 50 per cent of the adult population of this county take some medicament every day, and 30 per cent of children. Public apathy is well illustrated by Professor Kessel (1965), who persuaded a pretty young actress to visit six chemists. She always appeared in tears, a picture of abject misery; she then asked for *two hundred* aspirins; she was not questioned and there were no refusals to sell her the drugs. The only gleam of compassion came from one chemist who went to the door with her and advised her to go home and have a cup of tea.

The contribution of the general practitioner

The blues or the blue plague is a major problem of our time. There has always been human suffering, physical, mental, and social; philanthropic, religious people like the Tukes of York have always been in the forefront of the battle to relieve it. Today when the plague is in epidemic proportions, only about ten per cent of the population go to church. Of the rest, many derive comfort from public houses, drugs, doctors,

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the social services and voluntary organisations like the Samaritans. This is a social sickness; not just a medical problem; certainly not just another task for the psychiatrists.

I cannot suggest a remedy, but I will outline the family doctor's role in the community as one of the first lines of defence. Aided by the psychiatric services, social services, and other bodies like teachers, the clergy, and the public itself, he has a useful part to play.

Everyday problems

Family doctors need to understand the social sciences, and need to learn the art of dealing with everyday problems not previously covered by the medical curriculum. Such problems often occur at the great crises of life: birth, starting school, marriage, severe illness, accident in a family and the ultimate crisis of death. There are many minor problems which are major upsets to the sufferer: a young mother tortured by the baby who refuses food or keeps parents awake night after night after night; messy things like bedwetting, school phobias, masturbation, sex problems, marriage difficulties; the change of life, retirement, and old age. There is a whole field of medical practice not clearly defined which lies somewhere between orthodox medicine and psychiatry, but which belongs to neither of these disciplines.

Some doctors think all reasonable people should be able to combat the stress and strain of life unaided, and as each problem is overcome by do-it-yourself methods, so character is moulded and improved. To ask for help is seen as a sign of a feeble personality. This thesis is partly true. We certainly have to learn to adjust to or circumvent some of the difficulties we meet.

I believe, however, that at times access to expert advice on the problems of our complex society can be helpful and is, indeed, necessary if it eases the painful path towards maturity; it does not necessarily sap morale.

Examples

A young woman doctor was discharged from a London maternity hospital to a top floor flat. After the first day she was on her own with her new baby, as her husband had to go out to work. The health visitor called after 24 hours and the doctor was both delighted and relieved by this simple routine visit.

My reaction was that this was a lonely young woman, yearning for company. For countless generations the young mother has always had such company, her mother or mother-in-law if she was poor, a nanny if she was rich. This reaction of relief showed me how human and like the rest of the herd was this bright young woman doctor; and I felt how very useful such routine visits could be.

One of my colleagues felt very differently. He suggested she should have been ashamed of herself for needing any such help after an expensive medical education; she had no right to seek moral support from anyone, and needless to say he felt that the health visitor was a waste of nursepower.

A nurse of 35 came to me requesting the ' pill '. She had three small girls—a large enough family. I gave her my usual talk on the subject, telling her the advantages and dangers of it. I suggested that it was aesthetically more acceptable than other methods and 100 per cent safe as a contraceptive. She said " That is just what I hate about the pill—you might as well be sterilized. I have enjoyed playing Russian roulette—I like feeling there is always an element of risk."

This attitude was new to me; I found it fascinating. The true *woman*, the primitive archetype in her was revealed in contrast to the usual facile philosophy of today. The average woman on the ' pill ' feels she is being clever and up-to-date, turning a blind eye as it were to the strong maternal forces within her which are being frustrated. I felt that this woman, who preferred the Russian roulette, had insight and was more mature than most. I am sure that my colleague who disliked the health visitor system would have suggested that such a woman was wasting my time. Why ask for the ' pill ' if you feel like that about it? In his view the surgery is no place for a philosophical

discussion, it is for taking blood samples, reading the blood pressure or dispensing — this is real medicine.

I once had the privilege of working on a committee of the Royal College of General Practitioners. We discussed this role of the family doctor. We decided that about 20 per cent of doctors had found ways of dealing with this kind of work. Some 20 per cent were like my colleague, they had no insight at all, and obviously would be unwilling to learn. We felt that the remaining 60 per cent of doctors could be taught, and the best time to learn this was as a student. Fortunately, most medical schools today realise the importance of this subject, and doctors of the future are likely to be better equipped for their work as family physicians. The new medical schools like those at Nottingham and in Leicester have shown a great interest in this side of our work; but in the meantime we, who are already in general practice, must learn more about this art by some form of postgraduate study. In this particular sphere we are very short of teachers. The orthodox medical school teachers cannot help us as the subject is outside their sphere.

One outstanding exception to this was the late Michael Balint (1964) who felt that if a practical form of psychotherapy was to be performed it had to be by way of the family doctor, and by his seminars he taught many to understand this new discipline.

When I started in general practice, my mentors all told me that good obstetrics was the backbone of a successful practice. This was indeed good advice 30 years ago. Today, the backbone of good general practice is a good knowledge and understanding of human behaviour, which encourages people to unburden themselves of their real problems, great and small. It is easy to diagnose and treat organic diseases, such as tonsillitis, measles, pneumonia, anaemia, or appendicitis. It needs extra skill to sort and help the ten per cent of psychoneurotics in every practice, and to cope with the stress component of much organic disease. Even with a physical diagnosis, some attempt should be made to find what the patient thinks about it. There are always two diagnoses, the doctor's and the patient's. If they both think the same, there is no problem, but if they are widely different, a cure of the organic disease will only give a limited relief. For example, if a man of 50 comes along with a boil on his neck, penicillin will clear the skin lesion. If he feels, however, that this is really ' the syphilis coming out, something he collected in the army 25 years ago,' a removal of the boil is not the complete answer.

To effect the best treatment, the doctor must realise that the patient is not completely satisfied. There is something intuitive about this process. The patient tends to linger at the door, and asks questions as to what has caused the trouble, and how long it has been in his blood. If the doctor is able to discuss the whole problem with him, and bring his fears into the open, then he is in a better position to make recovery complete.

The history of medicine

Depression which forms most of the blue plague, has been a special interest of mine for 27 years. Minor depressions are common and cause much human misery; this malady has been well documented since the time of Shakespeare. It would be difficult to better the description of mild depression which he puts into the mouth of Antonio, the merchant of Venice. Antonio was in no sense of the word mad, but he felt under the weather, and his business acumen was perhaps somewhat blunted:

> In sooth I know not why I am so sad,
> It wearies me, you say it wearies you:
> But how I caught it, found it or came by it,
> What stuff tis made of, whereof tis borne I am to learn,
> And such a want wit sadness makes of me
> That I have much ado to know myself.

How many of our depressed patients say just that: " Doctor, I cannot understand myself." Twelve years after Shakespeare's death, Robert Burton wrote his monumental

tome *The Anatomy of Melancholy*, and in this we can see some real progress both in an understanding of the mechanism of depression and its treatment. " Melancholy proceeds not from Devils as they (the patients that is) suppose, or that they are bewitched, or forsaken of God as many think, *but from inward and natural causes.*" This phrase is more discerning than the term functional which was applied three centuries later. The beginning of rational treatment were also suggested. Confession of troubles to a reliable friend was advocated; wine and opiates were advised for insomnia.

Three hundred years later in the middle of the nineteenth century, a famous German pathologist, Virchow, by his work on cells, placed the study of disease on a scientific basis and the old humoral theories of medicine that had been the basis of our discipline for some 2,000 years were banished.

From Virchow's time, all respectable disease had to be based on the structural alterations of cells, and any condition which did not fit this category was described as functional, and functional illness carried with it a derogatory connotation, patients were said to be hysterical, hypochondriacal, immature, inadequate, or lacking in moral fibre. The severe mental breakdowns continued to be recognised as a true illness; rather frightening disease entities, but mild depressions and anxiety states which afflict most of us some time in our lives, were swept into this disgraceful, functional category. Victorian society could perhaps allow women to have the vapours, but not men. Medicine had emerged from the dark ages as a respectable science, its best brains were captivated by the new enlightened outlook and swept forward to produce the ever increasing flood of material miracles and advancements—very few were attracted to investigate the awkward, unhappy and rejected victims of ' functional disorders.'

Charcot in Paris showed an interest, but the first advance in this field came from the work of Sigmund Freud and his disciples. There was a time when the analyst's couch seemed to have the solution to all our problems; all one needed to understand oneself and become a mature person, was to have a complete Freudian analysis. If this was indeed the answer to the blue plague, we would now be in a disastrous position, how many can afford an hour a day five days a week for many years, at £5 or £10 per session? There is no doubt that Freud did discover *some* of the psychopathology of emotional and mental illness. More important, he goaded the medical profession to think again about such problems which were being either locked in asylums or ignored.

When Robert Koch discovered the tubercle bacillus in 1882, the world at once decided that having found a cause, a cure was just round the corner. How wrong the world was. It was over 60 years before the discovery of streptomycin made the conquest of tuberculosis—the white plague—possible. Freud's theory of the ego and the id have done no more to cure mental illness than did Koch's discovery of the tubercle bacillus.

The next historical step was the discovery of physical methods of treatment. At first, they were cruel. Having a fit by a camphor injection produced a ghastly feeling of impending dissolution, before the merciful oblivion of the fit—and after the first treatment, the patient lived in terror of the second; but many recovered in a dramatic way. Cynics suggested it was the fear of the treatment which produced the cure, but this was not so. Convulsive treatment today is quite painless and is just as effective.

Drug therapy in the late 1950s, for the first time, placed an effective tool in the hands of the general practitioner to treat one aspect of the blue plague. As a family doctor, I feel that the major tranquillizers and antidepressant drugs have been as helpful to me in the field of psychiatry as were the antibiotics for the infective diseases. At present we must admit that this drug treatment is empirical and only vaguely understood, but surely it is leading us to an answer to some of the mysteries of mental illness?

The late Professor Frank Fish, himself a victim of the blue plague, used to say that if

antibiotics had been discovered before germs, we would be in a muddle with penicillin and the antibiotics. Some fevers would respond in a dramatic way, others would not. Some doctors would praise antibiotics, and others would criticise them, but still continue to use them.

Charles was a business executive during the war when he had his first depression. He was admitted to a mental hospital for a year before being allowed home; even then he was far from well. He was given no active treatment. In 1956, he had a second depression. He refused to return to a mental hospital, but a sympathetic psychiatrist who accepted my word that ECT was necessary gave it as an outpatient. He improved rapidly and returned to work. In 1963, he had a third episode, and like so many depressed patients he was reluctant to come to me, let alone return to the psychiatrist. He said that he could not face another course of ECT. He was given imipramine, without improvement, so I changed to a monoamine oxidase inhibitor, and in two weeks this worked. I told him he would need them for some time, he replied that he would take them for the rest of his life if they kept him so well. He stated he felt better and clearer in his mind than he had felt for 20 years. His wife told me the same story when I saw her one day, in every way he was a changed man.

The ECT given in 1956 had improved him, but he had never truly recovered, it had, as it were, left him in a state of arrested depression. The monoamine oxidase inhibitor had restored him to normal, or even put him into a mild, productive state of hypomania. He remained well in every way until five years later when he suddenly died of coronary thrombosis.

Anne was a girl of 23. She seemed to be in a classical acute schizophrenic state of only three days duration. She was very agitated and felt that people were talking about her. She heard voices, and said that the girls at the office had said that she was pregnant. When she left me she went off to report her troubles to the police. After conferring with her parents, I decided to use massive doses of chlorpromazine, until we could get psychiatric help after the weekend. As it happened, we had to wait a week for the appointment. She responded to the drug by sleeping most of the time, and I kept her on a high dose for six days. I then reduced it drastically so that she would be awake to talk to the psychiatrist. When she saw him he could find no evidence of psychosis, and she has remained well ever since. That was eight years ago. She was on drugs for three months in all.

Discussion

Not all cases respond as satisfactorily as the examples I have described. Some 20 per cent of depressions do not respond to any form of treatment and become chronic. There is no room for complacency. Having said this, I must emphasise that the major tranquillizers, including the anti-depressant drugs, are tremendously important weapons which, at present, we do not fully understand. I am sure that there are better yet to come.

While I am impressed by the judicious use of so called major tranquillizers, like Parish (1971), I am appalled by the misuse of the minor tranquillizers like chlordiazepoxide, diazepam, meprobamate, and the massive dispensing of sleeping tablets, by general practitioners and hospital doctors alike. I will admit in my time I have used these drugs as liberally as anyone. In my own defence I must point out that when I started work on depressed patients in 1946, the only tools were the hypnotics and amphetamines including purple hearts. They were the only drugs but they were marginally effective.

After 25 years of work on depression, I have come to the conclusion that any drug which tranquillizes rapidly, which relaxes or puts the patient to sleep, is a potential drug of addiction. It is easy to start these drugs, but very hard to stop. I now hardly ever prescribe them to new patients. Many are prescribed in enormous quantities, several hundred at a time. Presumably this is done to keep the tiresome patient away from the surgery for as long as possible. It is, however, dangerous to overprescribe as many of these drugs are potential suicidal agents—and they are all too often used for this purpose.

There is a place for such drugs in a crisis. The spouse confronted with the sudden death of a partner may need heavy sedation at night for a week or so, and perhaps a sedative by day, *but only for a limited period*, and the patient should be told this from the start. I think we should treat this kind of drug with the same respect that we have for

steroids and opiates; these are wonderful drugs in short sharp courses, but habituation has to be avoided, except in terminal care.

Drugs then have a place in the treatment of psychoses and often in depression, but in the treatment of anxiety they are of dubious value. How should we treat the multitude of patients who have problems, who are anxious, worried and distressed?

The management of anxiety

Long term, time-consuming, expensive, psychoanalysis as a practical form of treatment is impossible for most people. Is there any practical way of helping such people? I think there is and that any family doctor with the proper experience and training should be able to do this work.

In dealing with the anxious patient there is no drug as effective as the listening ear of the doctor or one of his social workers, and this may be all the treatment that is needed. If the patient indicates that a prescription is expected, I am prepared to prescribe vitamins or some harmless placebo, which can be a great comfort to the patient. Someone once suggested that the bottle of medicine was the doctor sitting on the mantelpiece. I agree with the American physician who said that the doctor who objected entirely to the placebo, had better turn his hand to veterinary medicine.

The war allowed me to study psychiatry in a military hospital. I saw many interesting patients, and not depressing hordes of chronic, longstay patients who were generally regarded as incurable. Here I was able to learn the art of dealing with the kind of patient, whom in pre-war practice I had tended to avoid. I had all the time in the world to spend on this work. I learned to listen at length to peoples' stories; to guess by their sweating faces, their tears, their silences, the handkerchief tied in knots, or the wedding ring constantly twisted on the finger; to spot the important parts of the interview from the smoke screen; irrelevancies from things that mattered. The doctor must appear to have infinite time and patience, and there is no place for a slick answer or sarcasm. The patient who already feels humiliated must not be made to lose face in this process of uncovering the embarrassing areas of his life. I learned to pose awkward questions without upsetting the patient. It isn't easy to ask, " Do you hear voices? " or to inquire about suicidal feelings. It does take time and practice to develop such techniques.

I hope my methods have improved and now I am able to help people to undress in a psychological sense with as little embarrassment as in undressing for a physical examination. Neither process is entirely pleasant to a normal person. At first this type of work took an immense amount of time, but as the years have passed I have learned many short cuts, and now I rarely spend more than 20 minutes in a session with any patient. Many can be given much help in a shorter time.

I believe what is done matters less than our attitude of mind, one which creates the atmosphere in the surgery that any problem can be discussed, no matter how trivial, absurd, or disgusting. The patient has lost confidence in himself, and the whole object of the manoeuvre is to restore that confidence and a sense of self respect. I have little faith in the idea of digging up the past, hour after hour. It rarely helps and is very extravagant in time. There are sometimes problems which have to be considered. Often these people are bewildered, like travellers lost in a foreign land. The therapist is like a stranger who can speak their language and help to direct them onto the right road again. The patient who finds such a guide is greatly relieved.

Young doctors entering general practice should spend at least six months in suitable psychiatric hospitals, or in psychiatrically orientated practices. Experience in both spheres would be best. The trainee should have as much time as he wants to talk and to listen to his patients. He should also visit as many clinics and centres as possible, to review different methods. With better training and experience this new type of general

practitioner would have the satisfaction of being able to help considerable numbers of patients back to full health and usefulness, instead of fending them off with tranquillizers, or dismissing them with cold disdain.

Conclusion

The blue plague is very obvious in every section of society today. It presents an enormous challenge to people in every walk of life. I imagine that the clergy are also seeking its solution. Teachers must be revising their methods of education when so many young people seem perplexed, and some cannot cope with adult life. Parents must certainly now ponder their influence.

Why do some of the most advanced communities in the world have the highest suicide rate, divorce rate, and alcoholic addiction rate? Social workers know the problem well, and they are concerned with ways of meeting it. The man in the street can hardly fail to be aware of it, and many, of course, show their sense of alarm by supporting Samaritan schemes.

I have tried to outline how the family doctor can help. As a medical and social worker in the community, he has a vantage point. He must, however, be trained to recognise and manage the large proportion of emotional problems which occur among all of us. This sort of work is not as time-consuming as many imagine, and it can give the greatest satisfaction to both the patient and the family doctor himself.

Acknowledgement

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THE FRANCIS HARDEY FAULDING MEMORIAL AWARD 1971

Dr K. R. Heber, M.B., B.S., M.R.A.C.G.P., has been awarded the Francis Hardey Faulding Memorial Award for 1971 for his thesis *Anti-ovulatory steroids.* The Fellowship, which carries an award of $2,500 was presented at the Annual General Meeting of the Royal Australian College of General Practitioners in Sydney in October 1971.

Dr Heber's work was on the balance of oestrogen and progesterone in contraceptive pills. He concluded that side-effects were more often associated with progesterone than with oestrogen, and that depression, loss of sexual desire and irritability were the most frequent side-effects from progesterone. He believed they were associated almost exclusively with high strength of progesterone 19 nortestosterone and that these side-effects were uncommon in preparations containing 17 hydroxyprogesterone.

Annals of General Practice: (1971). **16,** 227.