PREVALENCE OF CORONARY HEART DISEASE

Sir,

I very much enjoyed reading Dr M. C. Stone's Mackenzie Lecture (January *Journal*). I wish, however, to take issue with him over some of his interpretation of Mackenzie's work. He states (p. 11) that: " clearly at this time (during Mackenzie's life) the disease (coronary heart disease) must have been relatively common in the well nourished section of the community, though it was certainly not being diagnosed frequently in either general or consultant practice ".

Mackenzie himself demonstrated that it was common in his Burnley general practice which was not confined to or even largely among the well to do. In his *Diseases of the Heart* published in 1914 (third edition) he describes 41 cases which are readily recognisable as angina pectoris and/or myocardial infarction. Thirty-two of these were seen while he was a general practitioner and only nine while he was a consultant. This would suggest to me that while it is true to say " that this disease was not being diagnosed frequently in either general or consultant practice " it would be very rash on the available evidence to make any statement about either its absolute incidence or its incidence by social class.

I cannot accept that Dr Stone's statement " We have exchanged the heart disease of poverty, overcrowding, and undernutrition, for the heart disease of the affluent society, with gluttony, cigarette smoking and physical inertia as its standard bearers " has any basis in known fact other than the decline in the incidence of rheumatic heart disease.

The incidence and the true mortality from ischaemic heart disease at the turn of the century are now impossible to establish, but Mackenzie's careful histories should make us very sceptical of assuming a very substantial real increase in order to bolster our beliefs regarding its aetiology.

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REFERENCE

Stone, M. C. (1976). *Journal of the Royal College of General Practitioners*, **26**, 7–16.

INVESTIGATIONS IN THE PRACTICE

Sir,

Dr Hooper in his letter (December *Journal*), lists a comprehensive array of " office procedures ", and I am sure that he is to be congratulated on his versatility. I have to confess that my sigmoidoscope has been languishing in a top cupboard for 25 years, and I certainly cannot lay claim to such expertise.

I wonder if he would agree with what I wrote in describing my practice in 1953 " that the absurd situation exists when the satisfaction of fully treating one's own patients is becoming a luxury which few doctors can afford "? Would he perhaps set my mind at rest on two points, which I feel he can only have omitted because they are too obvious? Does he use his microscope regularly, and also a haemoglobinometer? Without these two simple tools I would feel very poorly equipped.

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REFERENCE

Hooper, P. D. (1935). *Journal of the Royal College of General Practitioners*, **25**, 908.

PSYCHOTHERAPY IN GENERAL PRACTICE

Sir,

Psychotherapists are commonly considered in the same light as Druids, and believers in fairies: harmless enough, so long as they don't expect you to believe in all their unscientific jargon. Discussion of intractable and painful clinical problems in terms of having " within herself, a black and violent side . . . a dangerous black lodger ", is something that can easily be held up to ridicule. These are not areas into which the average competent British clinician will willingly enter.

All the more reason therefore, to welcome the long and instructive article by Brook and Temperley (February *Journal*) from which the above quotation is taken, who step boldly into this " no-man's " land, in a worthy attempt to demystify the " myths and magic " of psychotherapy.

Having myself had a through grounding in psychotherapy in this country, and in psychoanalysis at the Psychiatric Institute, New York, I have been amazed by the degree to which my earlier psychiatric training has proved invaluable for everyday general practice. Indeed, I entered general practice intending to pursue my interest in family interaction, a move entirely justified in the event, and I can strongly confirm the authors' conclusion regarding the unique opportunities offered in general practice. In particular, as they rightly emphasise, emotional problems can be caught, and dealt with sooner, and in surroundings familiar to the patient. There are indeed many who benefit from early brief psychotherapy, who would not countenance referral to psychiatric outpatients.

I would emphasise the vital importance of the relationship built up with the patient during frequent minor consultations for coughs, and other so-called " trivia ": this personal knowledge and mutual acquaintance adds enormously to the impact of reassurance and other psychotherapeutic intervention, in a manner quite outside my experience as a hospital psychotherapist.

While therefore giving a warm welcome to this article, perhaps I might open the debate that is called for, by commenting on the terminology, and the theories behind psychotherapy. During

the last eight years in general practice, I have found that my use of specialised terms has shrunk, in the interests of better communication. Thus, in the case of Mrs A, mentioned above, I would prefer to talk in terms of her "bottling up" violent emotions such as anger, with which she has been unable to cope, over the years.

There is no doubt that the early pioneers, especially Freud and Jung were responsible for filling the subject with mystical and in some cases contradictory and nonsensical notions, and this in part explains the Tower of Babel we have today. On the other hand, psychotherapy is a form of treatment in which the therapist actively, and we hope consciously, uses his or her personality to identify and, over a period of time, unravel emotional handicaps and conflicts.

Psychotherapy is thus indispensibly a practical matter. Evidence suggests that the actual theory adopted has little impact on the efficacy of the treatment: in other words, despite radical differences in theory, the practical results of different therapists are often very similar. Bearing this in mind, I adopt the simplest possible theoretical structure, whose outline is readily explained to the patient, and along whose paths the patient is gently guided. Lacking a prestigious psychiatric post however, publishers have shown little interest.

I am confident that many general practitioners already use their personality as a major factor in their management of patients. If I might comment on one who has recently and courageously displayed his own approach to these tricky problems, namely Dr Wilks (October *Journal*), who prescribes as many antidepressants as I do tranquilisers (at 48 per cent of total psychotropic drugs prescribed), though I had a slightly lower rate of attendance (2·7 per patient per year). Though I would happily disagree with some of his precepts, I am equally sure that his patients benefit from his firm and straight forward approach.

During a similar period of 12 months, already reported in part (Johnson, 1972), I found that 9·5 per cent of all consultations resulted in prescription of a tranquilliser, 4·5 per cent an antidepressant, and 5·7 per cent a hypnotic. It is instructive to note that 4·5 per cent of all consultations entailed "reassurance" as part of the treatment offered, and only 0·9 per cent elicited an explicitly psychotherapeutic intervention. (The latter figure would certainly rise in subsequent years.) This is a vital topic, whose clinical importance must steadily grow. It involves difficult and elusive concepts: yet with suitable guidance, one's expertise can be improved remarkably. I am delighted to see the matter tackled so bodly in your *Journal*.

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CHECKING INTRA-UTERINE DEVICES

Sir,

Doctors Henderson and Hull (February *Journal*) stress the importance of patients checking their own intra-uterine contraceptive devices. I wonder how important this really is. Many patients experience great difficulty in detecting the presence of the tail of the device in the upper vagina, particularly when the cord has been cut short and retracted to the external cervical os. Some patients are psychologically unable to perform a digital vaginal examination on themselves.

The significance of checking the device as determined by the pregnancy rate of those who checked their device compared with those who did not, was given by these authors in table 3. Unfortunately these figures do not support the desirability of checking the devices since they could have arisen by chance. When tested by either the chi squared test or by the approximation of the binomial distribution by the normal distribution, the proportions shown in this table have a probability greater than the accepted five per cent.

There is, therefore, no justification in stressing the importance of patients checking their own devices.

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REFERENCE

Henderson, J. M. & Hull, F. M. (1975). *Journal of the Royal College of General Practitioners*, **26**, 147–149.

APOLOGY

Sir,

The College Treasurer has pointed out to me that a phrase in the obituary of Dr G. V. O'Connor (February *Journal*), looks like a criticism of the Finance Department of the College. I would like to make it clear that I was responsible for misinforming Dr O'Connor.

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REFERENCE

Barley, S. L. (1976). *Journal of the Royal College of General Practitioners*, **26**, 125.