

general practitioners, although many such patients are not seen by specialists: a diagnosis of schizophrenia or psychosis; the use of long term maintenance medication, such as lithium, even if the patient was not actively ill; patients with disrupted work or social relationships caused by chronic mental illness, particularly those requiring long term sick certification in general practice; documented affective disorders such as anxiety or depression present for longer than six months (this included patients taking regular medication for the prevention of such disorders); and dementia.

Drug and alcohol abuse and chronic uncomplicated benzodiazepine use were excluded as they have different management problems. Morbidity from short term psychological disturbance was also excluded by including only those patients who had had problems for at least six months.

At least 119 (3% of the practice population) could be considered to have a chronic mental illness. This may be an underestimate because some affective disorders may go unrecognized when a patient presents with physical symptoms only (somatization¹). Furthermore, even when recognized, some chronic mental illnesses such as dementia or chronic neurosis may not be clearly documented as such in general practice notes.

Physical illnesses such as diabetes require not only physical care, but a holistic approach to care which must include attention to the psychological and social aspects of a patient's illness. The reverse is also true of patients with mental illnesses: their physical health must also be attended to. In the second part of the study, record keeping of the measurement of risk factors was compared between patients with chronic mental illnesses and the next age and sex matched patient on the file who did not have a chronic mental illness. The patient with a chronic mental illness was more likely to have his or her notes summarized than age and sex matched controls (94% versus 78%). The former group of patients were less likely to have blood pressure recorded in the notes in the last five years (64% versus 73%), less likely to have smoking habits recorded (24% versus 36%) and less likely to have alcohol habits recorded (23% versus 31%). This suggests that general practitioners may focus too narrowly on the psychological component of chronic mental illness and more attention should be paid to routine screening measures.

Appropriate teamwork between the specialist psychiatrist and primary health care team is essential but the difficulties should not be underestimated. Specialist

psychiatric services, including community psychiatric nurses and clinical psychologists, are usually based away from primary care, and may not develop a clear understanding of the potential and constraints of general practitioner care. Also, in an inner city practice such as our own, with high patient mobility, there is a risk of fragmentation of care and a lack of continuity. In central Manchester close links are being developed between the psychology department at Manchester Royal Infirmary and general practitioners, and the liaison psychiatry model² has been used to good effect.

The liaison psychiatry model and studies of general practitioners trained using video feedback³ show that general practitioners' consultation skills can be improved and this could also improve their care of the mentally ill. To develop this further, planning to improve community services for mentally ill people should include continuing medical education of general practitioners and the primary health care team. There should be an emphasis on two way learning between general practitioners and specialists. Detailed case discussion can build on the general practitioners' strengths, including their knowledge of the patient, family and community and a unique awareness of the impact of mental illness on family members, as well as helping specialist services to learn more about primary health care, making their services more appropriate.

Developing explicit management aims for patients with chronic mental illnesses, combining the skills of specialists and of general practice, and monitoring standards could help to improve services for chronically mentally ill patients. The purchaser-provider split must not prevent the development of strong coordinated, multidisciplinary mental health services firmly based in primary health care settings.

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Flourishing process — floundering care

Sir,

I reject almost in its entirety Geoffrey Marsh's chilling vision of a truly holistic community based caring system (editorial, *July Journal*, p.266). What is described is process and only process. No mention is made of outcome, whether defined by the patient or the doctor.

I have grave doubts about much that we do. I have even greater doubts about the benefits of much of the work of health visitors,¹ physiotherapists, speech therapists, community psychiatric nurses and social workers. The thought of grouping all these workers together in the name of progress is frightening. New buildings, smart uniforms and medium and high technology facilities are attractive, but I hope we can see beyond these material things to what is truly important.

The job of general practice is to respond to, and where possible help the patient who perceives him or herself to be ill. Patients turn to their doctor for care. This means interest, understanding, concern and where possible help, and all of these must be provided dependably. If we dilute this care with sub-specialization in disease, with management responsibility, and with even more patients, we will have created a monster. The monster would be pleasing to the eye and attractive to the powerful, the healthy and the opinion formers, but alien to the poor, the sick and the confused.

While abroad I have worked in such an institution. It had 20 doctors, two of whom were not seeing patients but managing, a laboratory, an x-ray department, a physiotherapy department and an ophthalmology department. I saw the future and I found it wanting. I fled to a small practice and later accepted the secretaryship of the Small Practices Association.

No amount of welfare can make good the deficit of a parent. Now I know with equal certainty that no amount of management and technology, no amount of resources or support will make good any degradation of the patient-doctor relationship. We must endure this time of uncertainty and reject any superficially attractive goal which could detract from basic personal care.

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