the diagnosis. The clinical features of our patient did not suggest that she suffered from one of these virus infections.

Considering all these facts, I thought that the patient had developed "definite" (according to A.R.A. criteria) sero-negative rheumatoid arthritis. Rheumatoid factor was present in synovial fluid and it will be of interest to see if she also becomes sero-positive in the near future.

MANAGEMENT

In addition to aspiration of the knee, a local steroid injection was given and the joint was splinted. A steroid injection was also given in her left elbow. By now she was four months' pregnant and, therefore, we felt safer putting her on phenylbutazone, as aspirin had not relieved the symptoms significantly. The patient responded well to this treatment and joint inflammation subsided within a short period. After this she received physio-

therapy to mobilize her affected joints and to strengthen her muscles. She made steady progress and her symptoms at present are those of mild twinges of pain with minimal morning stiffness. She was delivered normally by her general practitioner of a normal girl seven months after the onset of her illness.

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General Practice Observed

Working with the Family Doctor: A Programme for Mental Health

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Summary

A new type of assessment for mental health in four Scottish counties has been based on multidisciplinary teams comprising psychiatrists, psychiatric social worker, nursing administrator, and a secretary. Each team collaborated with 15 to 20 family doctors and they established four main patterns of contact: around an outpatient clinic; by informal availability; by administrative and teaching seminars; or by regular consultation sessions. This improved contact was found to help both the team and the family doctors and reduced the number of patients admitted to hospital and the length of their stay and the number of urgent referrals. It emphasizes the need for team work in mental health care and that the hospital needs to remain in touch with the outside community.

Crisis of Referral

In 1965 we at Dingleton Hospital began to look closely at the process by which patients came into the hospital. It appeared that the referral was always the end of complex processes which were hard to understand. So we established a policy that a patient would be admitted to the hospital only after an assessment of the crisis precipitating the referral and that if, in an emergency, this was impossible before admission it would take place as soon as possible after. This assessment was to be carried out by a multi-disciplinary team consisting usually of psychiatrist, social worker, and ward nurse, together with the family doctor if possible and any other party concerned in the crisis. The task was seen as establishing clearly who was asking for what kind of

help and understanding the chain of events which had led to this plea.

Admission to a psychiatric hospital is sometimes precipitated by a developing illness. Often, however, it is precipitated in a person who has long been ill or even in a healthy person by a breakdown in his social system—by separation from someone close or because he is being rejected by his social group.

It came to be an accepted view at Dingleton that the referral might be a cry for help from any participant in the crisis, including the family doctor, and not simply from the patient or his family. An appreciable number of patients were referred by locum practitioners when their own family doctor was on holiday, and several doctors commented that their referrals to the hospital were affected by other pressures on them, such as a measles epidemic, the sickness of a partner, or preoccupation with a personal problem.

The Family Doctor and the Hospital

The family doctors' first reaction to the hospital's new assessment procedure was to feel it as a direct challenge to their authority, as well as a reflection on their competence. Faced with the doctors' obvious irritation we invited all 60 of them to an open meeting at the hospital to explain the new ideas and to seek comment and criticism of the hospital's services. About half of those invited came.

Some of the criticisms made at this meeting referred to incidents which had occurred many years previously, and clearly there was much resentment about both the past and the present. There were four main complaints. Firstly, that the consultants made themselves inaccessible and seemed reluctant to respond to urgent appeals at times of crisis. Secondly, that a patient "belonging" to a family doctor was handed over to the hospital and was then lost to him entirely. Thirdly, that delays in communication exposed him to unexpected contact with patients thought to be in hospital, or prevented swift follow-up after the

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patient's discharge. Fourthly, that the new assessment procedure and the greater use of domiciliary visiting by a team from the hospital for handling crises and for geriatric assessment were an intrusion on the territory of the family doctor and unnecessarily threatening for the patient and his family.

The hospital staff were equally critical of the unthinking way in which some referrals were made, of "unnecessary" requests for urgent admission, and of the "possessiveness" of some family doctors towards their patients.

There were many lessons to be learnt from this meeting, the clearest of all being the inadequacy of the existing channels of communication between the family doctor and the hospital. Nevertheless, this meeting, which at the time felt largely re-crematory and defensive, did much to clear the air for more constructive action. Later a similar response was experienced in contacts with ministers, social workers, teachers, police, district nurses, and others, and it does seem that where strong undercurrents of anger and misunderstanding exist it may be necessary to tolerate a period of heightened tension and anxiety before a new social structure can begin to emerge. It would be tragic if this early—admittedly discouraging—phase were seen as typical of future relations and the process were abandoned at this point.

Patterns of Contact

After some months of internal discussion the hospital introduced a county team system in which a consultant psychiatrist, a registrar, a psychiatric social worker, a nursing administrator, and a secretary were given responsibility for the mental health programme of a particular geographical area.

The Roxburghshire team served a population of about 44,000 centred on three small towns, none of which was more than 15 miles (24 km) from Dingleton; the Selkirkshire and Peeblesshire team served a population of about 31,000, of which two-thirds were within seven miles (11 km) of Dingleton and one-third was about 25 miles (40 km) away; and the Berwickshire team served a population of about 22,000 scattered widely in a rural countryside up to 40 miles (64 km) from Dingleton. The same teams were responsible for wards within the hospital. The pattern of this responsibility evolved for a year or two, and eventually each team looked after a geriatric unit for all the elderly from its own catchment district and a long-stay unit providing a particular function for all areas and shared responsibility for the small admission unit. Each team was responsible for relationships with 15 to 20 doctors, scattered widely, and they made contact with them as seemed appropriate; characteristic patterns of contact developed in each area.

CONTACT AROUND AN OUTPATIENT CLINIC

In some of the more outlying areas outpatient clinics were established in a local facility such as the cottage hospital. This was to meet practical difficulties with transport in rural areas and to help the doctors to refer some of their patients who still regarded the psychiatric hospital as the old asylum. The doctors were encouraged to attend interviews with their own patients and particularly to join the initial assessment of new patients; after some hesitancy many of them did so. To supplement this contact we held a quarterly meeting in the area served by an outpatient clinic, to which all the referring doctors were invited, to discuss current clinical practice and the needs of the area in an up-to-date way and to iron out misunderstandings more or less as they arose. These general discussions also helped the hospital team to gain a better understanding of the locality.

INFORMAL AVAILABILITY

Some of the teams made themselves available to the local family doctors in an informal way. For instance, one team stationed it-

self in the local cottage hospital for one hour a month so that family doctors who wished to do so could contact them there. It was possible to deal with the routine business and also to have more general discussion with those who wanted it. Nevertheless, this was essentially a way of reaching those who already had a special interest in mental health.

ADMINISTRATIVE AND TEACHING SEMINARS

One team arranged bimonthly discussions with all the doctors in its area together with local authority social workers, district nurses, and the staff of local hospitals. These sessions were used for discussions about policy and occasionally for direct teaching. Attendance was remarkably good so long as matters of real concern were being tackled, but it was difficult to deal with problems relating to individual patients or with disagreements affecting only a single doctor.

REGULAR CONSULTATION SESSIONS

In these the team, or some of its members, met routinely with the doctors in their natural working group, sometimes together with local nurses and social workers. This type of group seemed most successful in handling misunderstandings about policy or personality clashes. In 1968 we decided to try to establish this kind of machinery for communication throughout the four counties, and two years later the teams were meeting at least monthly with 48 out of the 56 family doctors in the immediate catchment area. For the hospital this pattern had the advantage of enabling it to understand changes in the mode of referral or sudden displays of anger or anxiety on the part of the doctor. For the doctor it relieved many of his difficulties in understanding changes in hospital practice or the reports which he heard from his patients.

Dr. A., for example, was very insistent that his patient, Mr. P., should be admitted to hospital. Though the grounds seemed rather slender Mr. P. accepted the idea. The psychiatric team reluctantly admitted him but found him quite uninterested in changing. Local gossip picked up by the nurses suggested that people thought Dr. A. was having an affair with Mrs. P. Medical ethics, conventional loyalty, and personal cowardice would normally encourage one to dismiss this kind of gossip. But it seemed important because of the nature of the case to be quite sure about the facts, and the team took it up with Dr. A. at the next consultation. He dismissed the gossip as untrue but went on to talk about the difficulty of offering support to a very demanding woman without becoming a substitute for her passive husband. The pain and distress suffered by Dr. A. in handling both Mrs. P.'s demands and his own flattered responses were evident and went a long way to explain why it was so important to him that Mr. P. should become more effective.

The problem is familiar and easily conceptualized as one of "transference and counter-transference." This family doctor chose not to defend himself with professional brusqueness, became involved in an emotional process, and then needed help to handle it. His own solution—admitting the husband to hospital—was not effective and put him in conflict with the hospital. Often conflict is masked by professional formality:

Dear Dr. A.,
Your patient, Mr. P., has proved unco-operative and we discharged him last week. He is taking 50 mg of placebo daily and we have instructed him to report to you when his supply is finished.

and by private outburst—"What use is psychiatry?"; "Consultants spend all their time on the golf course." "The P.'s again." But the only constructive help lies in understanding the emotional transactions—how all the people concerned are using one another.

At the other extreme of the medical spectrum was the doctor who wrote: "Dear Consultant, Please see Mr. Q. and curb his

garrulity." This letter came from a family doctor who disliked emotional problems. It conveys contempt for both the patient and the psychiatrist and is guaranteed to anger the latter. Yet this kind of letter is in some ways more helpful than a ream of medical and social history. It states very clearly why the patient has been referred and is an honest letter. The doctor who wrote it amplified it roughly as follows when seen at the next monthly consultation:

"Look, I am very busy; I have at most five minutes per patient. This Q fellow was in my surgery every night that week talking at me. He would not leave. I even shouted at him "Get out and don't come back." So I am punishing him by sending him to you [laugh]. I know he has character problems—has had for years. I can't help him; you can't help him; but at least he'll be off my back for two weeks."

These two examples show the family doctor under extreme emotional pressure. When he asks for help for his patient he is also looking for relief from his own stress. The psychiatric hospital can offer help by admitting the patient or by accepting the emotional stress in outpatient care. But often these are inappropriate responses or short-term ones or are rejected by the patient. Then the family doctor is in the firing line again. The mental health services frequently withdraw at this point and the doctor is left without support. Monthly consultations provide an opportunity for supporting the family doctor beyond the point at which the mental health services normally withdraw.

The function of consultation sessions is clearly professional—to help the hospital service and the family doctor to work together more efficiently. But the sessions also constantly tend to move into a social relationship in one direction or a therapeutic relationship in the other. Each of these has its dangers. A social relationship is based on doing things together because they are enjoyed for themselves or on being together because of mutual liking. Clearly a relationship of this kind may help work to be done because communication is made easier, but a social relationship may inhibit aggressive or critical communication. The mutual enjoyment may be preserved at the expense of good work, and it may lead to seeing good work as the product of an individual's personality alone rather than of proper professional structure, which may make it hard to hand over or to build on. At the other end of the scale good work undoubtedly involves exploring feelings and understanding the way in which personality affects function; it involves admitting personal weakness and recognizing strengths. But if these processes are not mutual or if people are left feeling exposed it may become impossible to share work difficulties easily and, in extreme cases, may cause so much anxiety that the relationship is destroyed.

Practical Consequences

Some highly practical results to which the closer working relationships contributed were as follows.

Number of Admissions.—Much more of the hospital's work was done through outpatient clinics, and the admission unit was reduced from 35 beds to 10.

Length of Stay.—The average stay for acute psychiatric patients fell to three to four weeks, as opposed to eight weeks in 1968.

Number of Patients Admitted on Certificate.—The family doctors knew that if they insisted on the urgency of a situation the hospital team would come immediately. This created confidence that he would be relieved of responsibility, and as a result certification was hardly ever used to put pressure on the hospital. In many cases admission was averted altogether by an on-the-spot evaluation of the crisis.

Number of Urgent and Overnight Referrals.—If a doctor has confidence that a patient will be seen more or less as urgently as he requests, and that the patient's reception will be improved by waiting for the regular team to be available, it becomes both

unnecessary and undesirable to use "back-door" methods of referral. Naturally emergencies did occur, but it was amazing how many of these were, in fact, foreseen and not dealt with.

Setting up Consultations

This programme evolved to meet practical needs, but there were several conscious steps. The first was the decision not to admit a patient before proper assessment. The second was the organization of the hospital so that the teams related to catchment areas and, in particular, to a limited number of family doctors. The third was the extension of the consultation model to the whole area.

This third step was taken with some diffidence, in the knowledge that family doctors vary enormously in the way in which they perceive their role. Some are clear that they want to work in a multidisciplinary team, of which they will be the leader, based on a local centre, using flexibly the skills of the different members of the team—doctor, social worker, nurse, and possibly teacher, clergyman, and so on. Other doctors remain much happier and possibly more efficient when they see themselves as isolated practitioners, having access to specialist services when they require them but not routinely exchanging information with members of other disciplines, nor indeed seeing the necessity for the involvement of other disciplines in many cases. If one takes these two models as the extremes of the family doctor's perception of his role it is clear that the approach from the psychiatric hospital must be somewhat different.

Experience at Dingleton Hospital, however, suggests that in 9 out of 10 cases it is possible to open regular channels of communication by simply asking for them. The usual beginning was to arrange a meeting with the practice whatever it consisted of; to use this as an opportunity for reviewing the support each service gave the other, and the demands made by each side; and then to explore the possibility of setting up a regular forum. A simple proposal that the team should meet with the practice once a month met with easy acceptance, if not always with enthusiasm, in most cases. Sometimes this was an informed acceptance by a doctor who was clear that he himself would wish to have liaison; sometimes the acceptance was merely passive, out of respect for the hospital's staff, or an inability to resist a direct approach.

The occasional unwillingness to establish a regular meeting seemed sometimes to mask anxiety about confidentiality, about allowing others to see one's work, about difficult relationships within the practice, or about the sharing of treatment decisions. These were recurrent themes in all the consultation discussions and are, of course, fundamental issues for any kind of effective team work.

It was invariably asked why such meetings were wanted, and usually the following reasons were found quite acceptable.

(1) That mental health care requires close team work by many disciplines and services; (2) that in such a changing and confused field it cannot be assumed that conventional role definition is good enough, and a regular comparison of expectations is therefore important; (3) that this is best done in discussion of particular cases and as soon as possible after misunderstandings have arisen; (4) that a better exchange of information about patients can occur face to face than can occur by letter; and (4) that at the very least the hospital needs help to remain in touch with the outside community.

By this last argument the family doctor is asked to do no more than respond to an appeal from the hospital. He is relieved of all responsibility for liaison and is not expected to take any initiative. This is obviously not an ideal working relationship if one's goal is the establishment of an effective community link, but it is a safe beginning for a relationship and provides a foundation on which different kinds of contact can be built. Any discussion of an individual case must involve many issues relating to therapeutic techniques or administrative organization, and it is not hard to

develop these themes once the problem has been weighed and appreciated in a particular case. If this kind of discussion is handled effectively the development from the individual to the general makes it easy to establish the need for regular contact—for reporting back on the way the doctors' suggestions are received at the hospital, or for continuing a discussion which has been left unfinished—and it may be possible to move gradually from the individual case to the whole community as the focus for mental health care.

This programme was evolved by the entire staff at Dingleton Hospital in weekly reviews of its practice. Dr. Maxwell Jones (physician superintendent 1962-9) was the leader of the hospital, and much of the thinking stemmed from his concept of multiple leadership in a multidisciplinary setting. The admission assessment procedure was worked out under the leadership of Dr. Paul Polak between 1964 and 1966. Joy Tuxford's action research project, involving an attitude study of all the family doctors, between 1966 and 1969 stimulated and crystallized thinking about the relationships between the hospital and the family doctors.

New Appliances

Monitoring Pacemaker in Treatment of Acute Heart Block

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Dr. EDGAR SOWTON, consultant cardiologist at Guy's Hospital, London, S.E.1, writes: Heart block developing during cardiac infarction is usually of short duration provided that the patient survives, but the block is intermittent before sinus rhythm is finally re-established. There is wide variability in the duration of the heart block, and occasionally patients remain in or have recurrent episodes of block for periods longer than a month (Fig. 1).^{1,2} Often it

FIG. 1—Time of onset of heart block and duration pacing catheters remained in patients.

is difficult to decide when artificial pacemaking should be withdrawn and when the temporary electrode should be removed. The present apparatus, developed in conjunction with Devices Ltd., 26-8 Hyde Way, Welwyn Garden City, Herts., was designed to help with the latter problem.

Apparatus

The equipment is in two parts—an external demand (ventricular-inhibited) pacemaker and a small monitor which can be plugged into the pacemaker when necessary (Fig. 2). The pacemaker functions in the conventional manner and has protection against interference signals. In the presence of overwhelming interference the pacemaker reverts to fixed rate pacing.

The monitor incorporates a memory which stores information from the pacemaker and can be interrogated when a but-

FIG. 2—Demand pacemaker (right) and monitor (left).

ton is pressed. If three or more consecutive pacing impulses have been supplied by the pacemaker since the interrogation button was last pressed then a red "YES" lamp lights. If the pacemaker has not supplied three consecutive impulses then a green "NO" lamp lights. Single impulses from the pacemaker or a sequence of two impulses will not activate the red lamp. Releasing the button clears the memory of the monitor.

The function of the monitor differs in principle from that of the simple, paced-beat counter, which sums all pacing impulses delivered by a demand pacemaker. Occasional ectopic beats followed by a compensatory pause might well result in a demand pacemaker delivering a single stimulus although heart block had not returned. These would be added up by a paced-

FIG. 3—Typical chart showing variation of apex rate as sinus rhythm is re-established. ● = "No" lamp (green) lights on interrogation. ○ = "Yes" lamp (red) lights on interrogation.