THE GENERAL PRACTITIONER AND THE PSYCHIATRIST

A STUDY IN CO-OPERATION

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The introduction of the domiciliary visit has in many cases brought about a closer liaison between the general practitioner and the specialist. Visits to the patient's home and to the practitioner's surgery, and close acquaintance with the social structure of the district in which the practice lies, are of particular value when the specialty concerned is psychiatry. Since 1949 a relationship has developed between a group of four partners in a general practice and a psychiatrist which is believed to be mutually beneficial. We shall attempt to describe some of the experiences arising from this association.

Description of the Practice

The practice consists of approximately 14,000 N.H.S. patients. Most of them are from the lower middle class, and they live in a compact highly urbanized area of London, consisting of street after street of rows of houses. Semi-detached houses are uncommon, detached houses even more so, and there is only a sprinkling of flat-dwellers. The district is one of the few in London where large blocks of flats have not been erected since the war. The average house consists of front and back rooms, kitchen-scully, three bedrooms, and bathroom-lavatory. Gardens are not common. An air of respectability pervades the area, and most of the families have lived in the district for many years. The large super-cinema is missing, and instead there is a small old-fashioned picture house. There are few public-houses, and churches are none too evident a feature of the landscape. The whole area, in fact, is a later nineteenth-century residential suburb, with all that this implies. And yet, with all its imperfections, its inhabitants are fond of their district.

Two main surgeries and a branch surgery serve the four partners who run the practice. An efficient full-time secretary is employed, together with a receptionist. All four doctors live in their own houses, away from but within easy reach of the surgeries. The relationship between four temperamentally different doctors is excellent, and the practice appears to the psychiatrist to run smoothly and efficiently. The psychiatrist arrived on the scene in mid-1949 to carry out a domiciliary visit. Since that time all psychiatric cases have been referred to him, as domiciliary cases, as out-patients at the Maudsley Hospital, or as private patients. From this material there emerges a fairly clear picture of the psychiatric problems which beset the general practitioner, and of the help which the psychiatrist can give him and his patients.

Material

Roughly the cases have been divided into three categories—the domiciliary cases, the out-patients, and the in-patients; the last named will, of course, be derived from the first two groups. The private patients form such a

relatively small group as not to merit consideration here. The relevant information is as follows:

	1949	1950	1951
Domiciliary visits	6	22	40
Out-patients	—	23	62
In-patients	2	9	10

As shown, the number of cases in all groups has risen year by year. In 1951 approximately one-fifth of the psychiatrist's total domiciliary practice and one-fifth of his out-patient practice came from this one source. Given a practice of approximately 14,000 patients, the number of referrals (102) in 1951 is certainly not excessive—representing only one patient for every 140 “on the books.” Practitioners commonly remark on the large numbers of their patients who, according to their lights, either have “nothing wrong with them” or are “psychiatric cases.” And yet the number of cases referred to the psychiatrist by the average practitioner is very much smaller than the number referred by this particular practice. It may be that some doctors patronize several different psychiatric clinics, but this is not usual. The problem seems to be, first, that of selection, and, secondly, the attitude which the general practitioner takes towards psychiatry. Several surveys among medical students have shown that a majority opinion is extremely critical both of psychiatrists and of the claims they put forward. Prominent physicians and neurologists are likewise sceptical or even hostile, and as leaders of the profession must necessarily greatly influence the attitude of the average general practitioner. Much of this criticism is justified, but scarcely the hostility, for it leads to prejudice, and the patient may be an unwitting sufferer as a result. Clearly, a low opinion of psychiatry will deter the practitioner from calling in a psychiatrist.

The selection of cases is in many respects an even more difficult problem. If approximately 60% of a general practitioner's patients present neurotic symptoms, which of them should he refer to the psychiatrist? Or should he refer them to the local chemist for a bottle of medicine? The psychiatrist is also in a difficult position, for it cannot be said that unequivocal indications exist for certain types of therapy. And this is especially so where psychotherapy is concerned. What categories of patients is it worth while for the general practitioner to refer to the psychiatrist? Should the more severe cases have priority over the less severe, or vice versa? The methods of treatment are so time-consuming and arduous that these questions merit serious consideration.

It would be well, then, to consider the types of cases we have dealt with in these three years. They fall largely into four groups: the depressions, the neuroses, marital problems, social problems. Surprisingly enough, schizophrenia and mania, which are particularly associated by the public with mental illness, form only a very small group. Likewise, the psychiatric aspect of medical disorders has on the whole presented little of a problem to the psychiatrist. Although particularly interested in certain aspects of psychosomatic medicine, the psychiatrist has felt that the general practitioner and physician are best suited to care for these cases.

The role of the psychiatrist in the treatment of peptic ulcer, hypertension, ulcerative colitis, asthma, and other disorders in which emotional factors may be of importance has not been clearly determined. Extravagant therapeutic claims in this respect which cannot be substantiated do nothing to improve the relationship of physicians and psychiatrists. Only special research problems in this field have therefore been referred to the psychiatrist. Similarly, the general practitioners have not unduly burdened the consultant with geriatric problems, and particularly with the disposal of old people. So often the psychiatrist is called out when a practitioner cannot get an old person into hospital, or because relatives are pressing him to remove an elderly person—in some cases it must be said because the relatives no longer care to undertake their due responsibilities. If an adequate geriatric service existed the practitioner would find little need for a psychiatric opinion,

for these cases are not often abstruse or difficult problems of diagnosis or treatment. They do not compare with the problems presented by younger patients.

The Depressions

Of the four main types of cases, that of the depressive reactions looms the largest, and here the question of suicide is most often the reason for a consultation. Psychiatrists well know the difficulties of assessing suicidal risk, but it is astonishing how casually many medical men regard a threat of suicide. The casualty officer washes out the stomach of a patient who, let us say, has swallowed 100 aspirin tablets, and then sends the patient home; or the general practitioner dismisses a weeping young woman from his surgery with a bottle of sleeping tablets. These men are not necessarily to be blamed for their lack of psychiatric training. Of course, most patients who threaten suicide do not kill themselves, but every year there are, in fact, about 4,000 suicides in England and Wales. What, then, should the general practitioner decide when confronted with this problem? In this particular practice a psychiatric opinion has been obtained. This procedure has relieved the family doctor of a good deal of anxiety, and has perhaps saved many lives. Only one suicide has taken place in the practice over the three-year period, when it might reasonably have been expected, on statistical grounds, that six suicides would have occurred. It might be said by some doctors that it is over-cautious to refer to a psychiatrist all patients who threaten suicide, and time alone will tell whether this is a correct policy, but even if only one patient's life is saved it surely is a procedure which is worth while.

Apart from those subjects of depression who have suicidal thoughts and impulses, there is a large group of patients in whom the diagnosis is not self-evident. Hypochondriacal symptoms may mask the underlying depression, whilst, at the involuntal period of life in particular, psychiatric symptoms in any form may be the manifestations of a depressive illness. A correct diagnosis will lead to the appropriate treatment, and often to the speedy resolution of the symptoms. The natural tendency of most depressive disorders is to remit, but the process of recovery can be greatly accelerated. It has been the custom in this practice to refer to the psychiatrist all patients who fell into the group of depressive disorders. The following cases illustrate some of the points raised above.

Case 1.—A married woman aged 39 was seen on a domiciliary visit on January 16, 1950. She stated that she was four months' pregnant, and that the baby lay free within the abdomen. In spite of normal periods she believed she was being "torn apart" by the growth of the baby. She had also become depressed and apathetic, and lay in bed all day. She threatened to cut open her abdomen with a knife if the doctor would not "take the baby away." She believed her pregnancy was a punishment for her sins, particularly for her animosity towards her sister. She was admitted to the Maudsley Hospital on January 23. A diagnosis of depressive reaction was made, and she received 10 electric shocks. Complete recovery followed. Two years later a follow-up has shown that she is well, is working, and is symptom-free.

Case 2.—A married woman aged 21 was seen as an out-patient, having been depressed and "weepy" for the past three years, following the birth of her first baby. She complained of aching pains in the head and back, and felt that her body had been damaged during the birth of her baby. She felt that life was not worth living. She was three months pregnant when she married the father of the child, a withdrawn, unsociable Pole twelve years older than herself. Her family history showed that her mother was a hypochondriacal woman who had been unwell since the birth of her last child—her symptoms being almost identical with those of the patient—and that one sister drank heavily and was emotionally unstable. On examination the patient wept throughout the interview and showed evidence of many hypochondriacal ideas. She firmly believed her symptoms were the result of some unknown disease. A diagnosis of a depressive reaction with hypochondriacal features was made, and she was started on supportive treatment as an out-patient. A poor prognosis made it likely that she would need treatment extending over a lengthy period, with observation and a possible future admission to

hospital. Her suicidal threats were not regarded seriously, and, in view of the hypochondriacal features, no attempt at educative psychotherapy was made.

The Neuroses

The second large group of patients comprises those with psychoneurotic disorders. Here again there is much ground for discussion, but it has been felt that the treatment of these patients is largely beyond the capacity of the general practitioner. Although many neurologists regard themselves as qualified to treat neurosis effectively, psychiatrists recognize that special techniques and facilities, and psychiatric training, are necessary. Again the main problem confronting the general practitioner is that of selection. Unlike the depressive illnesses, it is not essential to treat neurosis, and the number of neurotic patients is overwhelming. In a large practice selection must inevitably be made, and an emphasis has been placed on age, intelligence, and severity of symptoms. By no means all of the neurotic patients referred to the psychiatrist have been suitable for treatment, but even in those cases unsuited to intensive treatment an attempt has been made to help the general practitioner with some of his more "difficult" patients. And it is useless to deny that many neurotic patients are a source of exasperation to doctors, and even to psychiatrists.

The chronically dependent patients, living on their monthly bottle and their five minutes with the doctor, may wear out the best of us—and the psychiatrists may give much-needed relief to the general practitioner with this type of case. With the young, intelligent, and comparatively well-integrated neurotic, treatment may be extremely successful; and good results will convince the general practitioner that psychiatry can be of help to his patients. It has therefore been the policy of the psychiatrist to concentrate his efforts on such patients, and to build up an organization mainly devoted to psychiatric therapy. The briefer forms of psychotherapy have been used extensively, in the main aiming at symptomatic relief.

Marital Problems

The third group comprises the marital problems—the patients who consult their doctor, not on account of illness, but because they are finding some difficulty in their marriage. The majority can be dealt with satisfactorily by the general practitioner, but there are cases which can be dealt with only by a psychiatrist. This is not necessarily to say that much can be done to help such patients; indeed, most commonly a legal and not a psychiatric opinion is indicated. However, when psychiatric symptoms have arisen as a result of marital disharmony it would be unwise to disregard them, and the general practitioner is best served when reinforced by a psychiatric opinion. Many of the irritations to the doctor caused by his becoming involved in legal affairs may then be avoided, for the psychiatrist should be more able to deal with such cases and to avoid legal entanglements.

Social Problems

This group comprises those in whom symptoms are related to social factors—loneliness, isolation, poverty, housing, unemployment. The use of the specially trained team of psychiatrist and psychiatric social worker may be of some value, their knowledge of social institutions providing a therapeutic link which the general practitioner cannot provide. Retraining for industry and the use of convalescent homes, of social clubs, and of the existing social services, can all be indicated in particular cases. The labour involved in steering the patient towards these services is often considerable, and can best be carried out by a psychiatric social worker, so relieving the general practitioner of a great deal of work.

From our experiences it is possible to give some indications of the type of patient who will most benefit from the use of the psychiatric services. The frank psychotics and mental defectives who are in need of care and protection or are a danger to themselves or others present little diffi-

culty in disposal. However, we believe that it is well worth while to obtain a psychiatric opinion in all these cases, if possible, rather than to send them direct to an observation ward. The depressed patient will also require more special supervision than the family doctor can provide, and will need psychiatric treatment.

It is with the large group of neurotics that most difficulties will arise. On the whole we have devoted our main energies to young intelligent people who show good evidence of dealing with most facets of life on a realistic basis and whose neurotic symptoms are of recent origin. There is a great reservoir of chronic neurosis, as of chronic physical ill-health, and it is unrealistic to believe psychiatry can deal with such cases at present. The physician has usually no illusions about the patient with a "chronic medical disorder," but too many psychiatrists believe that almost every patient who comes to them can be helped. We have had no hesitation in rejecting for treatment cases which we have considered as falling into the category of chronic neurosis. These patients have been advised to regard themselves as partially disabled and to live their life accordingly. Such advice has, of course, come from the psychiatrist. If it came from the general practitioner it would not be welcome. Home truths are seldom appreciated, and a too-frank practitioner is not always successful. The aura of specialism, however, often predisposes the patient to listen favourably to the advice the specialist gives him, and some excellent results have been obtained. The following is an example.

Case 3.—A spinster aged 46 had been a constant frequenter of her doctor's surgery for many years. She had had "pneumonia" as an infant and at the ages of 3, 16, and 42; "measles three times as a child and once at 27"; influenza at 27; appendicectomy and left ovariectomy at 29; arthritis at 20 and 42; tonsillectomy at 30; haematemesis at 32; rubella at 35; chronic nasal discharge, left antrum drained, at 36; pleurisy at 43; otitis media at 45; painful feet since childhood, for which she had had special exercises and boots; and acrocyanosis. This formidable list of complaints was no less formidable than her personality, which was that of a chronically dependent and yet aggressive woman. The psychiatrist was called in when her demands on the doctor were becoming increasingly impossible to meet. She was taken into hospital and a firm line adopted, so that her wheedling childish tricks were exposed to her. In addition a sympathectomy was performed for the acrocyanosis, the result of which was very successful. She was then discharged after several frank and critical interviews with the psychiatrist. On follow-up a year later she was much better, had seldom consulted her doctor, and was working part-time. The general practitioner is delighted; her multiple ailments have vanished for the time being, and if she shows the slightest sign of a return of symptoms she will be referred to the psychiatrist again. The fact that she has not transferred herself to another general practitioner is a hopeful augury for the future.

Comment

Cases of marital disharmony have on the whole proved unsuitable for psychiatric treatment, and the less the psychiatrist or family doctor is involved in cases of "mental cruelty" the better. Many patients primarily needing a legal opinion are referred to a psychiatrist. From our experience there is little to be gained from this. However, there is more to be gained when social factors are of importance in the genesis of the psychiatric symptoms, but a careful selection of cases must be made on a realistic basis. It is little use expecting the psychiatrist to remedy social defects such as poverty or poor housing, for example. In this type of case the responsibility for the choice of treatment lies particularly with the general practitioner.

The results of all this activity are difficult to assess over a three-year period. As spontaneous recovery may occur in 60% of psychiatric patients, it is clear that a good deal of the psychiatrist's work consists in tiding a patient over a current difficulty more speedily than can be done by the non-psychiatrist. In Victorian times maidens swooned or had hysterics, and were treated with sal volatile or a bucket of water, according to their class. Nowadays the psychiatrist is called in, but it has not yet been proved that his

work is often more efficacious than the two remedies cited. However, the changed pattern of medical practice, which recognizes psychiatric disorder as within the province of the doctor, means that the general practitioner is called in to more and more psychiatric patients. He cannot handle a certain number of these, and if he is concerned for his patients he must hand them on to someone who can deal with them. We believe that the close liaison we have developed is a useful one, from the point of view of the patient, the general practitioner, and the psychiatrist.

Correspondence

Post-gastrectomy Syndrome

SIR,—I was much interested to read the article on post-gastrectomy syndrome by Mr. J. Ewart Schofield and Mr. P. St.G. Anderson (*Journal*, September 12, p. 598), and, whilst agreeing that they have made an important contribution to the cure of the persistent afferent loop syndrome following partial gastrectomy for duodenal ulcer, I feel strongly that they fail to lay sufficient emphasis on the type of operation performed in the genesis of this particular syndrome. In particular I find their explanation that "as all our anastomoses were anterior to the colon, we cannot agree with Ogilvie,¹ who suggests anterior colic anastomosis as a possible cause of 'dumping,'" somewhat ingenuous in view of any lack of comparison with the numbers of afferent loop syndromes occurring in retrocolic anastomoses.

The authors confirm the view that afferent loop stasis and reflux play a part in the "dumping syndrome" and regard the weight of the afferent loop as contributory—a view with which I am in agreement—but the point which seems to be missed by the authors is that these factors are bound to be increased in antecolic anastomosis (as opposed to retrocolic) in proportion to the greater length of the afferent loop. As one who was originally taught and brought up on the antecolic anastomosis and who has changed in the last four years to a routine retrocolic anastomosis, I have been impressed by the freedom of the latter operation from afferent loop complications. In the course of some 85 gastrectomies for duodenal ulcer performed over the last two years I have had no case of dumping syndrome severe enough to even contemplate further operative interference. It may be, of course, that complications may yet occur, but at worst I feel that these cases are better than two of the three quoted by Schofield and Anderson, whom, it should be noted, developed their syndrome within eight months of operation. I believe with Ogilvie that the antecolic anastomosis is a potent cause of the "dumping syndrome," and I am of the opinion that less numbers of this distressing complication would be seen if the retrocolic anastomosis were more commonly used.

Finally, may I make a plea for greater accuracy in terminology? The term Polya gastrectomy should be reserved for the retrocolic anastomosis; the antecolic anastomosis should be called the Balfour gastrectomy after the name of its originator.—I am, etc.,

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REFERENCE

¹ *British Medical Journal*. 1952, 2, 299.

Dangers of Ethanolamine Oleate Injection Treatment for Varicose Veins

SIR,—Fostered by a first, and as yet only, allergic mishap with monethylolamine oleate, described in your columns some four years ago,¹ my interest in this matter has been reawakened by Mr. A. Lutton and Dr. G. H. Grant's letter (*Journal*, August 29, p. 510). In this litigious age where the published sayings of the not-so-great (a notable company of which I am happy to be a member) are apt to be quoted as evidence against some unfortunate defendant, one hesitates a while before expressing an opinion. Nevertheless, I feel that