The Patient whose Organisms are Resistant to Streptomycin, P.A.S., and Isoniazid

Such patients present a formidable problem, and no drug combination so far tested can give a guarantee of arrest of the disease and permanent conversion of the sputum to negative. Viomycin plus tetracycline may sometimes succeed in making those with milder disease fit for surgical operation, but it is unlikely to achieve sputum conversion on its own. Cycloserine plus tetracycline has similar limitations, in addition to the risk of toxicity from cycloserine. There have been a number of failures, with the emergence of drug resistance, on combinations of cycloserine plus pyrazinamide, cycloserine plus 1314, and pyrazinamide plus 1314. It is possible that the success rate can be improved by using three drugs in combination. Pyrazinamide together with 1314, if possible 0.5 g. twice daily, and viomycin 2 g., twice or three times weekly, may well be the best combination, though there is inadequate evidence regarding it. Cycloserine is perhaps best avoided as the third drug in order to reduce the number of pills which the patient may have to take and to avoid adding the toxicity of cycloserine to that of 1314 and pyrazinamide.

Drug Cover for Surgery

It must be clear from the foregoing paragraphs that none of the therapeutic combinations recommended are likely to be as effective as the standard drug combinations. In addition, patients with resistant organisms often have chronic and extensive disease. The probability of failure of chemotherapy and the emergence of drug resistance is therefore relatively high. In such patients resectional surgery, if it is feasible, is often indicated. The best time to carry this out in the individual case is a matter of judgment. In general, after three months' chemotherapy the patient's bacterial population will have been considerably reduced. If the sputum has become consistently less positive, even though negative cultures have not yet been obtained, it may provisionally be assumed that the tubercle bacilli are not yet drug-resistant. The chemotherapy in use should therefore be able to prevent infectious complications of the operation. Nevertheless, to be on the safe side it is probably wise to add an additional drug as operation cover. It is seldom possible to remove all the tuberculous disease, so it is very important to continue chemotherapy afterwards. The minimum duration should be one year after the first of a series of consistently negative sputum cultures, but in a severe case and if no drug toxicity emerges it is wise to continue for a total of two years regardless of when the operation was carried out.

Conclusions

The treatment of a patient with drug-resistant organisms is always a difficult matter requiring careful judgment of all the clinical, bacteriological and surgical factors involved. It is essential that the resistance tests, which will determine the chemotherapy used, should be carried out with skill and care and that wherever possible a decision should be based on more than one test. The physician must be capable of critical evaluation of the bacteriological results. The surgeon will often have to be consulted. It may be justifiable to ask him to take bigger risks than would normally be permissible, because the prognosis with chemotherapy alone, especially in the patient whose organisms are resistant to all three of the standard drugs, is so uncertain. Nevertheless, if all

concerned, including the patient himself, are prepared to take sufficient trouble, many of these unfortunate people can be salvaged.

NOTE.—References to original work on which some of these recommendations are based may be found in Crofton, J. (1960). *Brit. med. Bull.*, 16, 550

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AN APPRAISAL OF PSYCHIATRY IN GENERAL PRACTICE

BY

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The flood of mental illness with which the G.P. has to contend presents problems that are hard to solve. Some observers can see no solution apart from a fundamental change in either the patients or the doctors. In the meantime the immediate problem remains and becomes more pressing—namely, how to help the doctors as they now are to deal with the patients who actually consult them.

Psychotherapy

Strictly speaking, "psychotherapy" should mean all methods of treating the mind, but by custom it refers only to treatment by personal discussion between patient and doctor, and here it is used in this sense. The nature of the discussion and of any guidance and explanation offered to the patient varies widely, as do the duration and frequency of these interviews.

Each school of psychopathology believes in general that only psychotherapy practised within the framework of its own particular set of beliefs can be of real value. However, a non-partisan observer will hardly agree. The value of a frank discussion of one's personal problems and an airing of one's inner feelings has always been recognized. It has often been provided by organized religion, sometimes as part of an act of confession. In our modern secular society it is not surprising that the physician is frequently expected to take over this function, which was previously performed by the priest; it is, however, a function which the physician is often most reluctant to fulfil.

Nevertheless, psychotherapy by G.P.s is finding many strong advocates within the medical profession, particularly since Balint (1957) described his methods of training G.P.s at the Tavistock Clinic. One must admire his achievement of inducing G.P.s to continue to attend weekly seminars over a period of years. On the other hand, he reports that half of them did prematurely stop attending, and it appears from the lengthy case-histories he gives that more than half the patients remained ill despite many hours of work on

most of them. It does not seem that a strong case has been made for the usefulness of seminars of this type.

The present enthusiasm for psychotherapy in general practice is in some ways surprising, for psychotherapy is far from being an innovation, and it is not even a new technique in general practice. As long ago as 1923 Ross gave a clear account of its use in general practice in a book which was revised in 1937 and has been repeatedly reprinted (Ross, 1949). More recently there have been numerous reports on the use of psychotherapy by G.P.s in the National Health Service. I and my colleagues described its use in a practice that had been started in a rehoused community soon after the N.H.S. began (Franklin *et al.*, 1951), and there have been many other similar accounts.

Ten years' experience of psychotherapy in general practice has given me some clear impressions of its value.

A sympathetic ear and a kindness of manner are something which every doctor strives to offer every patient, whatever the illness. But I have found, as one would expect, that psychotherapy as a specific treatment is more effective for some psychiatric disorders than for others; I have found that the condition which responds best is an anxiety state in a young adult. Once a doctor has dealt as best he can with patients of this type who are on his list, the use of formal psychotherapy becomes fairly infrequent. A great deal of psychiatric illness will remain, however, which is unsuitable for psychotherapy or has not responded to it, and this in my view constitutes the main problem of mental illness in general practice.

For conditions other than an anxiety state psychotherapy may be ineffective and so lead to discouragement of both doctor and patient; in other cases it may actually be harmful, and it may make the patient worse even to the extent that his life is endangered. Therefore the basic medical discipline must be followed of trying to establish a diagnosis before starting treatment, lest one does harm by inappropriate treatment.

Five Main Groups

In my experience most cases of mental illness encountered in general practice belong to one of five main groups—namely, anxiety states, depression, psychosomatic disorders, schizophrenia, and hysteria. The diagnostic features of these conditions have often been described and will not be repeated here. The brief outline which follows, of how each can be tackled by the G.P., will help in evaluating the role of psychotherapy and of other treatments that are at present possible.

Anxiety State.—In my experience patients either respond quickly to psychotherapy or they scarcely benefit at all. As regards the number of occasions on which the patient should be seen, I have found that a law of diminishing returns operates, and if I have not made much progress after two or three interviews I have rarely made much more after a dozen. I have therefore given up undertaking prolonged courses of psychotherapy and rarely continue for as many as six sessions. To continue indefinitely when little progress is being made does not seem to benefit the patient very much and it may create difficulties for the doctor. If a strong

interpersonal relationship develops the patient may become very dependent on the doctor. On the other hand, for a G.P. to end a series of psychotherapeutic interviews is not the equivalent of a hospital doctor's discharging a patient from his care; a G.P. can never discharge a patient, and the doctor-patient relationship in general practice is virtually permanent. The doctor is always freely available to the patient, and their relationship is constantly developing.

Psychosomatic Disorders.—Although some of these are serious disorders which can kill through the somatic changes they produce, they nevertheless often respond to psychological treatment; I have found that they can sometimes be helped by psychotherapy, but often a great deal of work seems to produce little reward. I have found that there is another technique which is, fortunately, much more effective,—namely, hypnosis. An account of my use of hypnosis appears elsewhere (Franklin, 1957). It can be used for treatment by direct suggestion and also as an aid to psychotherapy. For example, dysmenorrhoea usually responds to suggestion alone, migraine and many cases of asthma to suggestion and a quite superficial discussion, while a few asthmatics need deeper psychotherapy if the initial response to hypnosis is to be maintained.

Depression.—This is a very common and very distressing condition and is an important killing disease. The number of deaths by suicide is comparable with the number of deaths from road accidents, and depression is the usual cause of suicide. The diagnosis of depression may not be immediately apparent as the patient may present with such symptoms as pains and lassitude. It is important to distinguish depression from anxiety state, which it may resemble, as the treatment of the two conditions is quite different. In my experience depression is scarcely affected by hypnotic suggestion and can be made worse by psychotherapy of any depth. The patient's feelings of guilt and unworthiness can be made worse if he is encouraged to recall unsavoury incidents from his past life, and the risk of suicide may thereby be increased. Psychotherapy should amount to little more than a sympathetic ear and an understanding manner. The principal treatment for depression is, in my view, physical rather than psychological. At present we have a variety of drugs as well as electroplexy, but we still await a completely specific remedy.

Schizophrenia.—This seems to be virtually uninfluenced by psychotherapy, and it is, in any case, difficult to establish a normal relationship with a schizophrenic when the disease is active. It is my opinion that, like depression, it calls primarily for physical methods of treatment. Recently introduced medicaments which have enabled chronic schizophrenics to be reinstated in society are encouraging. It seems that pharmacological and biochemical research may soon lead to a major breakthrough in both schizophrenia and depression.

Hysteria.—I regard hysteria as evidence of a major psychiatric disorder. Psychotherapy is difficult and is best restricted to a discussion of the patient's current problems. Contrary to what is widely believed, its treatment by hypnosis is difficult and potentially dangerous and is best not attempted in general practice. The fewer medicaments that are given, the better. Often the best that can be done is for both patient and doctor to accept the symptoms and not to look for a cure.

Symptom Tolerance

We can at present offer no more than palliative treatment to many of our psychiatric patients. However, we can sometimes help if we explain our limitations to the patient and encourage him to accept his symptoms and to carry on his life despite them. Those who can do so often find that their lives are transformed. Later their symptoms may disappear, possibly because of a remission of their illness, which would have occurred in any case.

There is, however, a hard core composed of psychiatric patients who in the present state of knowledge are virtually untreatable, but who do not need to be confined within a hospital. They are a constant worry to their G.P.s. Many of them have personality characteristics which make them tiresome and unrewarding patients. Even if the G.P. fails to give such patients insight into the nature of their illness he should try to see it in perspective himself. He should no more feel personally responsible for medicine's present inability to relieve these patients than he does for medicine's present inability to relieve many organic disorders. The doctor must learn to tolerate his patients having symptoms which he cannot cure.

Symptom tolerance can be a rewarding exercise for both patient and doctor.

Postgraduate Training

Though psychiatry presents G.P.s with some of their major problems, it was proved difficult to organize helpful refresher courses in it. Seminars of the type already referred to which meet regularly for years to discuss details of psychotherapy and the handling of the doctor-patient relationship have enthusiastic advocates. However, the reported results do not show that this is a method which should be generally adopted, and it is difficult to justify devoting so much time to a single technique.

I think that the following are some of the matters with which G.P. refresher courses could profitably deal.

Diagnosis.—A complete diagnosis is rarely possible in any branch of medicine, but diagnosis must form the basis of rational treatment. It is difficult to agree with Balint (1957) when he dismisses diagnosis as "irrelevant diagnostic tags." Diagnosis is irrelevant only if there is no effective treatment or if all conditions are treated in the same manner.

Therapeutic Techniques.—Instruction is needed in techniques that can be applied in practice, of which two come to mind: first, one of the well-tried methods of brief psychotherapy, and, secondly, hypnosis. G.P.s should have the possibility of becoming acquainted with hypnosis and its capabilities and limitations, even if they do not choose to use it themselves.

Physical Treatments.—All doctors use drugs in treating mental disorders, and most would like to know how far a rational basis for traditional medicaments is possible. One would also be grateful for any guidance through the maze of new drugs and their accompanying glossy promotion literature with which we are becoming surrounded.

Psychological Measurements.—G.P.s would like to know about methods of measuring different traits by

such procedures as intelligence tests and personality inventories, and to know how they can be applied clinically.

Research.—Information about research at the growing points in psychiatry is needed, particularly relating to the biochemical studies which seem to be breaking down psychiatry's previous frontiers.

Summary and Conclusions

Mental illness provides one of the main unsolved clinical problems in general practice. Much of it is amenable only to palliative treatment in the present state of knowledge and there is a hard core which is virtually untreatable.

Psychotherapy is a well-tried and valuable technique, but as a specific treatment it is effective in only a minority of cases; training in psychotherapy should form only a small part of postgraduate courses for G.P.s. The G.P. is greatly in need of help in the formidable problem presented by the patients who are not relieved by psychotherapy.

The potentialities of psychotherapy have been adequately explored and reported. There is little need for further descriptive accounts with detailed case-histories. Controlled studies of the value of particular treatments are needed, though they are difficult to carry out.

The next big advance in the management of mental illness in general practice is likely to result from the elaboration of new methods of physical treatment.

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VISION SCREENING OF VERY YOUNG OR HANDICAPPED CHILDREN

BY

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It is now generally agreed that the younger the age at which visual defect is diagnosed and treated the more favourable is the outlook for recovery or improvement of function. Earlier ascertainment depends upon appropriate methods of assessment. For some time I have been interested in the problem of testing the visual acuity of children, especially the very young, the mentally handicapped, the partially sighted, the deaf, those with cerebral palsy, and those with multiple handicaps.

Many years ago, as a result of discovering several school children with high myopia, whose disability had been missed until 8 or 10 years of age, and other children whose severe visual defect had been mistaken for mental backwardness, Dr. Gertrude Pugmire and I came to the conclusion that it was desirable to carry out routine vision-testing of 5-year-old school entrants.

The picture tests then available did not prove satisfactory, especially with retarded children, many of whom found difficulty in relating the black-and-white