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Human Relations in General Practice

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Introduction

It is frequently suggested that personal relationships between General Practitioners and their patients are all important and that the doctor's willingness to concern himself with his patients' personal problems and emotional difficulties is perhaps the most crucial part of his job. Others believe that the General Practitioner should function as a clinician and give off the personal problems of his patients to the psychiatrist, trained social worker and voluntary organisations

In order to provide a platform for analysing the importance of human relations in general practice the Office of Health Economics held a conference at the Royal College of General Practitioners in London, on Sunday 15 September, 1968. It was attended not only by General Practitioners and representatives of consumer groups but also by professional social scientists and social workers and members of the other branches of the medical profession and its auxiliary services.

In this report we have drawn together the major papers presented on that occasion and some part of the discussion which followed each paper. Unfortunately, space has precluded the publication of all but a few of the interesting comments made at the meeting.

Our thanks are due not only to those who gave the papers and to our Chairman, Dr John Fry who handled the meeting so well, but also to the many speakers from the floor who contributed so much to the success of the occasion.

JOHN McKENZIE

General Practice Today

G. Teeling-Smith

I WANT to set the tone for this symposium by linking our discussion today with the OHE Report, published a few days ago entitled, *General Practice Today*. I would like, first, to run quickly over the ground which that booklet covers.

In it, we pointed out that the intention of the National Health Service in 1948 was to provide the best type of traditional family doctor for everyone in the population. In the event, this has been achieved in many cases, but in other cases—largely because of manpower problems—we have now not got the sort of family doctor service which we hoped, prior to 1948, we could provide for every individual. On the other hand, in the twenty years since then there have been very radical changes in the technology of medicine and the pattern of morbidity. The fact that we have not provided the traditional family doctor for everyone is, therefore, probably now irrelevant. This is not the kind of doctor we need any more—the traditional Dr Finlay or Dr Cameron is not appropriate for the medical situation of the late nineteen sixties or early seventies. In the old pre-war pattern of general practice the doctor dealt to a large extent with individual acute illnesses, and almost always waited for the patient to call for his attention. Now, largely because the pattern of disease has changed, we are facing more and more the problem of the chronic and social types of disease. The pre-war pattern of practice is no longer the most appropriate and no longer makes the best use of medical and ancillary manpower.

More and more we are thinking in terms of providing positive health surveillance for the population. In this situation the general practitioner must have a positive role in maintaining the good physical and mental health of all the patients on his list. Thus today we increasingly have teams of doctors with 10,000 or more of the population under their collective care, using all the modern aids of technology and data processing to achieve the continuing good health of these people. These doctors think in terms of high risk groups. They are beginning to go out to look for people in the practice who could benefit from medical treatment instead of waiting for the patients to call on them. Obesity, diabetes and mental depression are good examples where you can provide great benefits by seeking out and bringing in for treatment, people in the community who have signs or symptoms of disease. This need not be a

costly or elaborate procedure. With obesity, for example, it can simply mean writing to everyone on the practice list and asking them to fill in and return a post-card giving their body height and weight. Those who are judged from the figures to be obese are called in for discussion or treatment.

We are now at the stage of thinking in these terms and starting to plan for this sort of approach. Above all, research is being undertaken to find, for example, which diseases benefit from early diagnosis and treatment and what type of medical records are most appropriate. The Royal College of General Practitioners is very much involved in this. Research is being started to find how to apply the principles of early diagnoses at minimum cost and with maximum benefit.

On the physical side this is relatively easy although even then the dividing line between sickness and health is often far from being clearcut. This symposium, however, is about the other aspect of health—mental health. One reason for this is that we want to restore the balance after the discussion which followed the publication of our booklet. This concentrated very much on the technological and organisational side of general practice and on the fact that the doctor will have to think more in management terms and will have to rely increasingly on modern technology and computers. This sort of approach always causes a very proper and understandable reaction among many practitioners, who say that they are not managers or technocrats. General practice, they remind us, is about people. This, of course, is entirely so; general practice must always be concerned primarily with clinical medicine, both physical and mental, and technology and management techniques will merely help the practitioner to fulfil his primary function. He will have to use machines and ancillary staff, but he must also retain his personal relationship with the patients under his care. Thus, the reason for this symposium is to discuss some of the social, sociological and personal aspects of the new general practice.

This, of course, concerns mental health in the broadest sense. Problems in this field are inevitably greater than in physical illness, where there are quantitative measurements such as haemoglobin and blood sugar levels. In mental illness the problems may involve quantification of, perhaps, matrimonial disharmony and neurotic

behaviour. Thus on the psychological side the problems of defining illhealth become very much greater. This is one aspect which, I am sure, will come up very much in the discussion today.

Another aspect is the extent to which, in the treatment of mental health, the medical profession will be taking over the role traditionally held by the family, the Church, or even paternalistic employers in small family businesses where the head of the firm often dealt with the personal problems of those who worked for him. Is this a role which general practice will have to take over? What is the extent to which problems are dealt with by the family as opposed to the doctor? In new towns, where young families are separated from their parents, there seems to be evidence that they call on their doctor more frequently. The suspicion is that they are seeking advice from the family doctor which, in the previous traditional city surrounding, they obtained from the family.

Another question which may come up in discussion is the way in which general practitioners in this personal-social aspect of their work should be and are co-operating with voluntary bodies such as Alcoholics Anonymous, the Samaritans and the WVS. What is the role of these voluntary bodies? I throw out the thought that they are excellent in stimulating progress in the early stages but it is difficult to integrate them at a later stage into the system of medical care where, if we are to get the best results, it is essential that they should be integrated.

Lastly, I can give a few figures which highlight the importance of what we are talking about today. These come from a survey organised by John McKenzie on our behalf among a stratified sample of 200 general practitioners. These practitioners were asked, among many other questions, what qualities they thought their patients looked for; what did the general practitioner think his patient wanted? The two top qualities which general practitioners thought their patients expected from them were, first, humanity, kindness and sympathy—54 per cent of the general practitioners regarded their patients as thinking this the most important quality—and second patience and tolerance, mentioned

by 32 per cent. You can contrast that with the next quality, technical ability; that rated only 21 per cent. Efficiency was mentioned by no more than 4 per cent. This means that general practitioners regard the personal aspects of their activities as being of overwhelming importance to their patients. These qualities were volunteered spontaneously by the doctors; they were not prompted in any way.

The doctors were then asked specifically whether they considered that they should provide advice on certain matters. In reply the following proportions felt that they should give advice on these subjects: contraception 93 per cent; other marital problems 83 per cent; upbringing of children 67 per cent; and employment problems 51 per cent. So, once again, one gets the picture from these answers of general practitioners who see themselves giving a wide range of advice, guidance and help by no means restricted to purely medical matters. This again helps to set the pattern for the discussion in this symposium.

To sum up: We see a new pattern of general practice emerging in response to new medical technology and new attitudes among the public to ill health. The public are expecting something different from the general practitioner. We see the general practitioner having a central controlling position, working with other doctors and a team of ancillary staff, using statistics and technology to provide preventive and therapeutic care for all their patients. The practitioner will, however, still remain very much a clinician and will also be very much concerned with these aspects of general practice we are talking about today.

The question which arises from this is the extent to which it is the responsibility of the general practitioner on the psychological side to seek out incipient personal problems and try to prevent mental breakdown among his patients in the same way as on the physical medicine side he tries increasingly to find ill health before it causes disability. To what extent should the general practitioner in future be undertaking preventive psychological medicine, taking over, perhaps, the past role of other people such as the Church and other organisations?

I AM convinced that at present and in the future, personal medical care must be developed as the centre-piece of our health and medical services. It is possible to believe this for sentimental reasons, or self-preservation reasons, but I think it is also possible to believe it on the basis of an analysis of the morbidity problems confronting our society and the available means of tackling them. I want to consider what the morbidity situation is which demands medical care and why we have not developed a more appropriate kind of medical care to deal with it.

I shall deal with these questions under three headings: The development of our current health situation; the genesis of our National Health Service; and the evolution of medical practice. Compared with 100 or so years ago, the morbidity situation in our country is very different. The population is very much greater and the population is of a much older age composition.

In addition, the sex ratio of the older population is becoming more female. If present trends continue, a very substantial proportion of the elderly population will consist of widows. Clearly, the population changes which have emerged in the last century pose a number of problems.

The reason for the population trends is mainly that mortality rates have been falling for the whole period for which we have reasonable data. They have fallen mainly because of improvements in standard of living, but also because of substantial measures of environmental control and because of the specific interventions of medical practice.

These various measures have left us with important residual problems. Although we are now largely rid of tuberculosis and many other infectious diseases, we are left with other important lethal illnesses arising before and during birth and in the process of aging, and we are also left with important non fatal morbidity problems.

At the same time that the population has been aging there has been a great change in the urban distribution of the population. Far more people now live in towns and far more work in industry than in agriculture. The effect of these changes on health, although principally due to the enormously improved nutrition, is also mediated by the changes in the quality of people's expectations from life.

Mortality between conception and the first month of post-natal life has scarcely changed in the present century. We still have a very high mortality in perinatal

life. Perinatal mortality is substantially influenced by the personal and social characteristics of the parents. If all newborn individuals enjoyed the perinatal rates that Social Class I newborns now enjoy, we should save more lives each year than are lost in road accidents and more years of human life than are lost from all forms of cancer.

In the later age group there are many problems. The first is that because mortality is concentrated in late life it is of necessity complex in causation.

The aetiology of the diseases which will continue to be important is enormously more complicated than was the aetiology of the diseases which we have now eradicated. In the field of non-lethal diseases, those which accompany aging become more complicated. Not only is the aetiological problem complex and the total load of such morbidity great but there seem to be a variety of biological, social and psychological reasons why elderly people do not report their state of health to doctors until disability is severe.

The other large area of morbidity which is gaining in importance is mental illness. It is often said that mental illness is becoming more frequent. I can find little evidence for this, but there is a lot of evidence that the attitude of the public and of the psychiatric profession has changed. The admission rates to mental hospitals have increased five-fold, but the number of beds has hardly changed. The major change has been that mental hospitals are very much less used as long-term custodial institutions and more as short-term accommodation for the treatment of a different kind of mental illness. The picture emerges of mental illness of a recurrent kind in which continuity of care through hospital and domiciliary episodes will be a common need.

In future, our health services will be less concerned with prevention because the diseases we shall be confronted with are too complicated to prevent. We shall be much more concerned with containment of illness, with the management of progressively deteriorating health and the control of the effect of illness on patients' lives. Prevention of many of the important diseases will involve the specific modification of individual environment in relation to the identifiable risk status of the individuals being treated.

A further important implication is that access to medical care is still not as good

The Development of Personal Medical Care

Professor Alwyn Smith

as it might be. The need for better access to medical care combines with the need for containment of long-term illness and the development of personally directed prevention to establish the need for the personal doctor. We must now consider why this need has not been met by our evolving National Health Service and what future developments will be required.

The development of public medical care in this country has been going on for a very long time. I want to make quite clear that I do not blame very much of our present state of affairs on the National Health Service Act, 1946—whose principal shortcoming seems to be that it failed to make any significant changes. The medical services of the country have been evolving over at least 400 years, and more intensively over the last 100 years. Various types of medical care have developed separately. The hospital services, even in 1948, were fragmented, with two quite distinct administrations: the municipal hospitals; and a large number of different kinds of voluntary hospitals. The present hospital service represents an accumulated legacy of isolated responses to contemporarily identifiable problems in a long and fluctuating history.

It is often said that general medical practice was created by the 1911 Act and preserved against extinction by the 1946 Act. There is some truth in this, in that some of the unhappy plight which general practice is in at present owes its origin to the 1911 Act and its perpetuation very much to the 1946 Act. I do not think this was primarily the fault of the legislators. In 1911 the attempt to set up a system of personal medical care was to a very considerable extent thwarted by the organised leaders of the profession, who were opposed to it. Very much the same happened in 1948 when the basis of independent contracting was adopted as a general principle, which has effectively isolated general practitioners from the rest of the profession.

I should like to consider briefly the evolution of medical care because I think the present structure of the service is partly influenced by this evolution. General medical practice probably did not exist in this country before the present century. The idea that there should be fully qualified and trained doctors who accepted responsibility for a large number of patients and a wide variety of morbidity is a relatively new idea. The 1858 Medical Act, which first set the profession on a respectable footing did not distinguish between general practition-

ers and specialists. The pattern of subsequent practice was profoundly affected by the question of whether doctors had hospital appointments or not.

If a doctor without a hospital appointment wanted a patient to be admitted to hospital, he had to refer to a doctor who had hospital appointments and it was an inevitable consequence of this referral system that doctors with hospital appointments specialised. Two kinds of specialism began to emerge: specialisation based on highly developed diagnostic or therapeutic skills, such as in neurology, orthopaedics or anaesthesia; and specialisation based on an identifiable class of patients, such as paediatrics and geriatrics.

The situation has now arisen that what was an unfortunate feature of professional practice is now a built in part of the Service. What can we do about it? Clearly, we must first have an idea of what we should like to do about it. On the world scale three different patterns of specialisation are discernible. In the developing countries generally there is little distinction between general practitioners and specialists. Both undergraduate and postgraduate training is essentially identical. In the British system there is a very sharp distinction between specialists who practise almost entirely in hospitals and control the type and number of patients they see, and generalists who have no control over patients sent to them and are accessible by ambulant and domiciliary patients. In the United States there is a highly developed system with virtually no general practice; almost all doctors specialise and there is very little personal or domiciliary care.

I do not think that we should accept either of these alternatives to our own system. The system in the developing countries is quite inappropriate to us and the United States system has the effect of fragmenting responsibility for personal medical care. I submit that what we need is the kind of personal doctor so admirably described in the writings of Fox. A doctor whose special concern is with the health and sickness of individuals and its relevance to their lives.

The personal doctor is the one referred to by the patient as 'my doctor'. This implies first, that a patient goes to the same doctor for each illness. Cartwright's recent study provides evidence that patients do stay with the same doctor to a substantial extent. Second, it implies that the doctor takes total control of the patients not only

in all stages of a particular illness but also of illnesses of every type that occur during his lifetime whatever the treatment that is required.

The personal doctor must be able to refer patients for certain kinds of specialised investigations and treatment beyond his own particular scope; it is impossible to think of the future of medical care without specialisation.

It has been said that doctors are not good at looking after people, but at diagnosing and prescribing. It has been suggested that we should introduce a new kind of profession into the field to help to look after the socially-supportive aspects of medical practice. It has been argued that the doctor's role in this aspect of his work was assumed only because no one else assumed it and that the present professional pattern lands a doctor with a lot of tasks for which he is not particularly qualified. This is the philosophy of the United States system; but there is evidence that the British public do not regard it as appropriate, and—as Mr Teeling-Smith has suggested—neither does the profession. They regard the whole complex of medical and social support of patients as part of the responsibility of general practitioners, although they do not altogether yet concede that there are specialist aspects of it for which they require the support of a specialist team.

I suggest that what is required in future is a doctor who is a specialist in this area of medical care, who has been trained in it and who has supporting facilities. I should be inclined to call him a 'general physician', rather than 'general practitioner'. Certain classes of hospital specialists would then not be necessary. Consultant general physicians would not be necessary. There is at present hardly such a thing as a general physician; almost all of them specialise in some branch of their practice.

I think that the care of people of whatever age is essentially the responsibility of this personal doctor. The problems posed by the young and the old are not basically different from those in the middle age range.

However, I believe that personal doctors will need to give up some kinds of interest which many would defend at the moment. I believe there is no place for the general personal doctor in obstetrics, which is far too complicated. As the emphasis shifts from care of the mother to care of the child; pregnancy and childbirth need a much more sophisticated and complex approach.

I feel that much the most important

development in medicine is personal medical care. We can develop it because we have physicians who, at least by circumstances and to some extent by subsequent training, are equipped to be personal doctors. In the future there will be problems for their education. As a closing sally, I should like to take serious issue with the Royal Commission on Medical Education and the Royal College of General Practitioners about postgraduate training in general practice. It does not seem consistent to suggest that they have a particular and characteristic concern with patients in the community and then to suggest that their training should consist of a series of house appointments in hospital.

Discussion

DR R. M. EMRYS-ROBERTS: Detailed discussion of human relationships in general practice should not be attempted without first defining the function of the general practitioner. Enthusiastic thinkers have suggested so many roles in recent years that even supermen would sink beneath the weight of them all. Whatever the GP does or does not must affect the work of others in the medical field. Only by considering his work in the whole context of medical care can proper decisions be made.

It is diverting and perhaps instructive to draw diagrams as an aid to conceptual thought and we can start with a cylinder which is intended to represent the whole of medical knowledge and care (Figure 1). Perhaps a century ago one capable country GP might have felt that he could encompass the whole, but even then the need for specialisation was recognised. The load had to be divided and shared. This fragmentation has been carried out in two ways—in cross-section according to age, producing obstetrics, paediatrics, adult medicine, general surgery and geriatrics and in longitudinal section according to organ or aspect, producing sector specialities such as ophthalmology, dermatology or psychiatry.

At first glance we might think that the problem had been solved. But if the diagrammatic cylinder is now turned end-on, and if we not think in terms of episodes of illness, some interesting points emerge (Figure 2). In this country about 90 per cent of episodes of illness in a good general practice are dealt with by the GP. Assuming that in a perfect world all episodes can be labelled with the appropriate speciality it is seen that the GP fends off nine cases for every one that the

specialist sees. This figure will vary according to the specialty (it is probably much lower in gynaecology) and also according to the particular interests and skills of each GP.

But immediately it becomes evident that in a country like USA, where patients go straight to the specialist, there must be a severe flooding of the specialist's time, creating the diluted specialist or specialloid.

There is a further fact to be considered. The cylinder, now representing again the whole of medicine, is expanding astronomically under the influence of technology. For instance the sector speciality of cardiology, both paediatric and adult, has an expanding surface of cardiac surgery which makes increasing demands on the supply of skills. Similarly, the specialist in aural surgery spends an increasing time on delicate operations and, therefore, has less time for the many other cases needing his advice.

Specialists worth their salt must have time to pursue their researches and apply new techniques. But being themselves not supermen can only do this by calling upon the help of other doctors—by hiving off some of their work onto registrars, houseman and clinical assistants. The chronic shortage of hospital doctors has already made it necessary to call increasingly upon the assistance of GPs. This means that many GPs are now acquiring a modicum of skills beyond their normal range in various specialist fields. But the GPs themselves have to find time for this extra work, necessitating off-loading onto partners or part-time assistants.

Here we come to the crux, because not only is the GP being asked to support the specialist, but concurrently there is a persuasive lobby for him to abandon his traditional role of doctoring sick people and devote himself to personal preventive medicine. However laudible this lobby, the pursuit of preventive medicine is highly time-consuming, and will leave the already hard pressed GP with even less time to devote to the care of the sick people.

If there was any likelihood of such preventive medicine halving at once the workload from sickness, there might just be a chance of the GP coping with both. But this is not so and even the ultimate ideal—the prevention of sickness in early and middle life—will be no more than a procrastination of clinical work. What is more, pre-occupation with preventive medicine, by reducing the time spent in contact with sick people, can only blunt the GPs clinical skill. The

GP is in danger of being torn into two inadequate parts.

If he is allowed and enabled to pursue clinical medicine to the best of his ability, his skill will increase with expanding experience. But if he deviates substantially from clinical medicine he must inevitably slide down the vicious spiral of contracting capability. The former GP, by referring fractionally fewer patients to the specialist, contributes considerably to the comprehensive care of all patients, whereas, the latter, by sending more and more cases to hospital, contributes only to clinical chaos. If for instance, GPs referred 20 per cent instead of 10 per cent the number of new cases at hospital would be doubled.

Consideration of human relationships in general practice must, therefore, be influenced by the function of the general practitioner—whether he is to be a preventive medicine expert and clinical sorter or a general clinician who is also keen on prevention.

DR D. L. CROMBIE: I think I agree with everything the first speaker said, so far as it goes, but I would put one thing into this cylinder. As the therapeutic problems enlarge, they leave behind them the ability to tackle those problems with much smaller resources than before for large parts of medical care—for instance, the treatment of serious mental illness by drugs. I feel as a GP that I can catch up with this increasing load. I feel that I am a more effective clinician than I was years ago because there are much more powerful weapons. I question whether the vicious circle is really a necessity.

DR P. HOPKINS: What Dr Emrys-Roberts said is all very true provided life is indeed a cylinder. Apart from assuming that life is a cylinder, he is assuming, I think, that the same number of doctors will continue to be working. If we try to fit in the amount of expanding work we have to do, we need far more doctors. Whatever thoughts we have and whatever plans we make, they must depend on an increase in the number of doctors and a reduction of the number of patients per doctor.

I am amazed that we can still meet together discussing these same basic problems when it all comes down to time and numbers. This is where we go on failing because we try to do with too few people and with

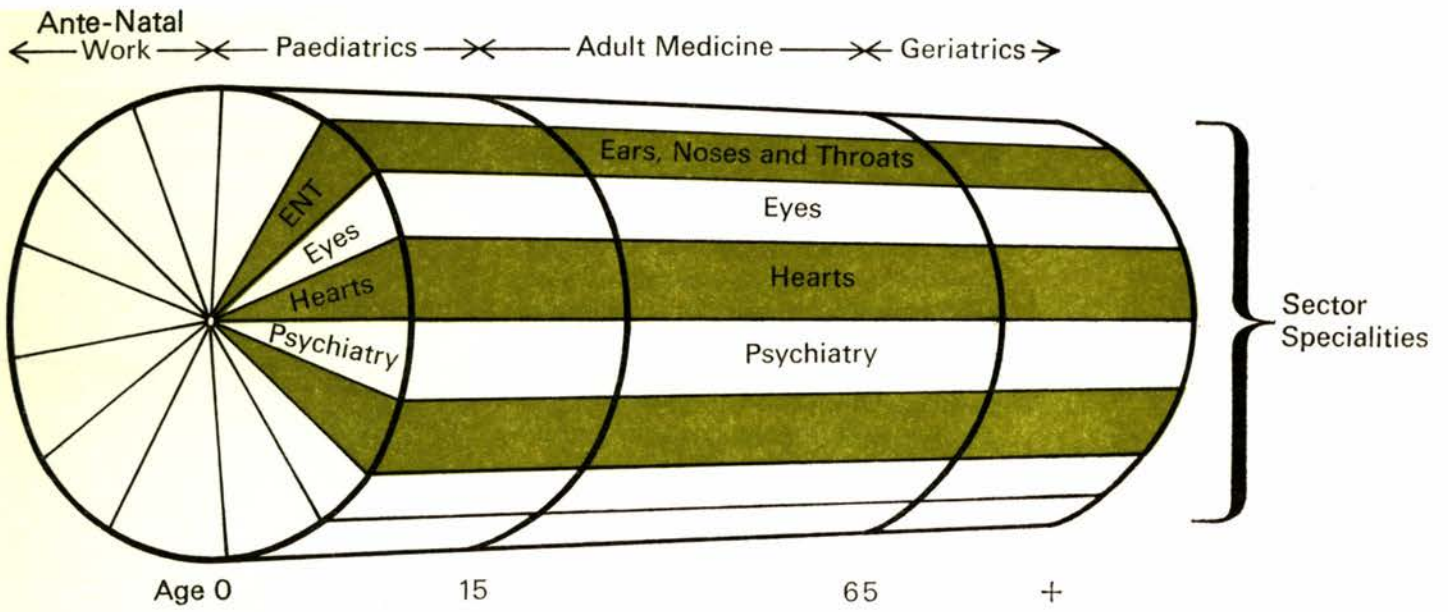


Figure 1. Medical Workload

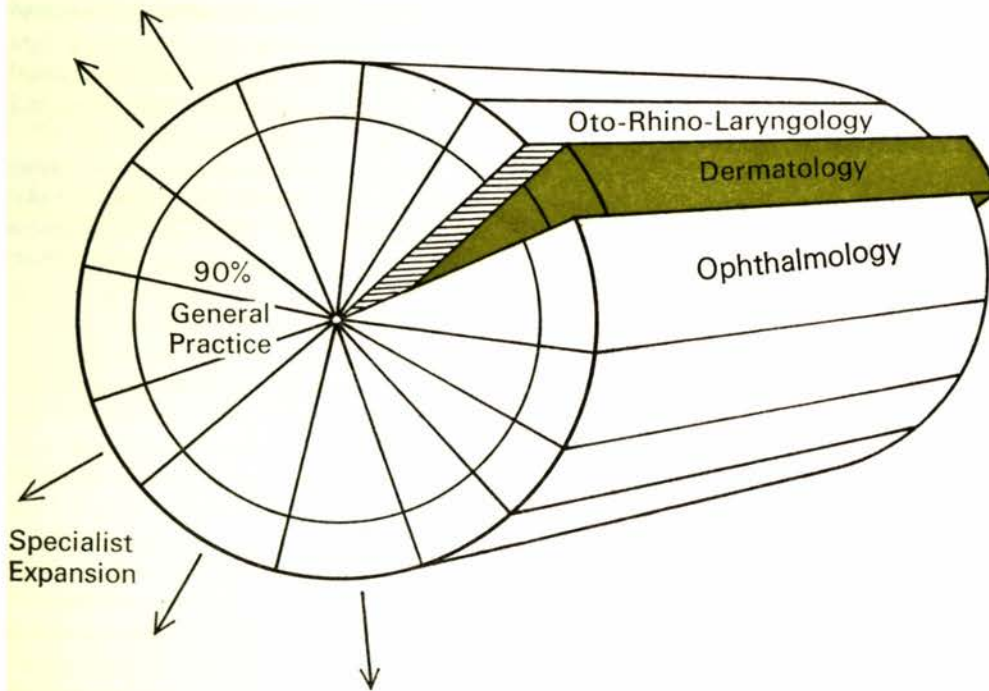


Figure 2. Cases dealt with in General Practice and by Specialist

too little time what we know demands to be done.

I suppose that Mr Teeling-Smith will admit that a lot was left out from the questions put to GPs. There was no mention of pre-marital and adolescent problems and all sorts of other problems which I am sure we must deal with.

Professor Alwyn Smith, in his excellent address, made several statements with which I should like to take issue if there were enough time. He said that in America there were no GPs. This is nonsense. When I was in America I spoke to a number of doctors who started by saying that they were specialists, but it was clear that each specialist will go on being a family doctor to a family until that family goes to another specialist. Almost all American specialists do what we call general practice as well, but they do not call themselves general practitioners. We call ourselves general practitioners, but I am sure that we act as specialists in all sorts of ways. We can deal with not 90 per cent but 96 per cent of all illness in this country. In dealing with it we act as specialists in all the speciality reaches, except the very big ones such as surgery and so on.

We take on the social and psychological problems because they arise not so much from what we call physical illness, and it is not that we must wait for ancillary workers to feed us with information on those problems, but because we discover them when examining patients with all sorts of physical illness. The problem is that we need more time per patient. I do not think we can develop a lot of relationships with patients if we can think of giving only 4½ minutes to each in the surgery.

DR J. PASMORE: Medical crises will always

occur, and discovery by early diagnosis will not stop them arising. One of our functions is to meet patients' demands. There is an increasing demand by patients for discussion of their problems. If GPs are to meet the demands of patients which are always there, the development of the future is that the GP must be better equipped to deal with those demands which cannot be met elsewhere.

DR J. CHAMBERLAIN: I should like to take up the last point made by Mr Teeling-Smith when he suggested that we should screen for psycho-social illness. Although screening will probably prove useful for several diseases and the general practitioner is probably in the best position to do it, it is difficult enough to prove it is of value in physical illness. Before attempting it for psychological conditions, much work must be done to define these more accurately, determine their natural history and show that treatment is effective.

DR H. J. CARNE: Whenever we hear a lot of GPs talking it seems that we always show our own frustrations and unhappiness. We always want to be something else, and we are always told by others that we should be something else. When we started we went into general practice because, presumably, it was the practice which we understood and in which we thought we would find satisfaction. All the time we are general practitioners we should be increasing our knowledge and awareness.

The doctor-patient relationship is terribly important, but we should go back to our training. We were not trained for this and we are not the only people who can deal with it.

THE GP's role in relation to his patients' sexual lives is different from that of other helping professionals in that he has ongoing contact with the family. He sees his patients at intervals throughout their lives and is present at many of their life crises—in particular, births and deaths—so let us consider his role in relation to the life crises of his patients as these affect their emotional development.

We bring to our work, each of us, our own philosophy of life and we are sometimes proud, sometimes ashamed, of what Dr Michael Balint¹ calls 'this apostolic function'. But it is an inevitable fact and, as such, is better recognised and admitted, for our attitudes are liable to cause harm if not openly acknowledged but excused by subterfuges; for example, an exaggeration of the risks of taking the pill instead of an honest admission that we do not want to prescribe it because we do not hold with teenage sex relations. Most of us regard a stable marriage as the mature expression of the sex relationship in our society and this is what we wish for our patients, though recognising that it is not possible for all. This is our philosophy.

If a stable and happy marriage is the goal, it is also the culmination of a long series of developmental stages in each of which the individual patients may use the understanding of their GP to help them to surmount the difficulties inherent in maturing. Sexual development is very much a family affair, and the GP can help because he is often in the family but not of it.

We do not know much of the pre-natal stage as yet, but the importance of the infant/mother relationship is well recognised. The GP is often the first to know when this is not going well, and a sympathetic understanding of the mother's anxieties may prevent tensions developing in the baby.

The next stage in the child's development is to include the father—the oedipal phase. This involves the problem of a triangular relationship, and here the GPs' awareness of what is going on may be enough to lessen anxiety in both parents and child and allow the inevitable frustrations to be tolerated in an atmosphere of warmth and ease. Such situations may be the first indication of a disturbed child or of disturbance in the parents and the marriage.

Then the arrival of a new baby may start off a series of reactions which, if not understood, may seriously hinder the child's later relationships—e.g., the girl who would

never compete with her younger sister was unable to consummate her marriage in case she did not do so well as her recently married sister who was pregnant.

The 'climate' of sexual attitudes in the home is of vital importance to the child's developing sexual feelings, and the GP unwittingly influences this climate by his own attitudes. It is better that he should realise how much his lightest word may signify for his patients.

In these early years it is the interplay between phantasy and reality which can be so disturbing. The GP has the opportunity for understanding something of the phantasy in the inner world of his young patients and yet standing himself for external reality. If he can facilitate the process of sorting out between the two—of 'reality testing'; e.g. he can recognise the child's wish to come between his parents, but also show the child that he cannot do this in reality, but only in phantasy.

In the crises of puberty and adolescence the GP has an even more delicate and important task in that he can respect and understand the needs of different members, and still be the 'container' of the family problems as a whole; he can remain a sympathetic outsider, unaffected by storms within the family. The GP, in his capacity as 'family doctor' demonstrates that the family survives as a unit.

The anxieties of adolescents about their physical development, and especially about their sexual organs, can often be handled with a knowledge and understanding of the relationships in the family background. For example, the girl who fears to develop because she knows her father has always wished she were a boy and has shared his fun in football or car mechanics with her; the boy who feels his penis has always been too small, because he felt 'too small' to look after mother when father died.

With the ending of adolescence the developing child should be reaching maturity and thinking of a permanent heterosexual relationship and of leaving the parental home. He or she may now bring his or her own problems to the GP. Here again the GPs' help may be needed to enable the child to separate from the parents and to relate as an adult to the future wife or husband. For example, 'It was really our GP who helped me to get away when I was 16'—although in this case the patient had to have an acute appendix before this happened.

The anxieties about sexuality in the group which can be thought of as the 'pre-mari-

Sex, Marriage and the GP

J. Pasmore

tals', and indeed in the next, or 'young-married' group, seems to centre round three areas:—1. The relationship to their own and their partners' bodies; 2. The social and emotional roles of man and woman; and 3. Ties with other important people.

1. Relationship to their own and their partners' bodies.

In our culture girls are still often expected to be unaware of their genitals in the long years between infancy and marriage, and so evolve all sorts of secret and half-conscious fears about them. Fear of pain is commonly associated with the phantasy of a skin—often thought of as right inside the passage—which has to be torn and has to bleed at defloration. Disgust about the genitals may belong to the 'cloacal' phantasy due to the primitive idea that one passage serves both for excretion and reproduction. This leads to remarks like, 'I couldn't touch myself down there'; 'I never let him do it with the light on'.

The boy is familiar with his genitals, but he may still have phantasies about the damage his penis may cause, or suffer—for instance the man who spoke of his penis as being like a potato masher which could break the bowl if rammed down hard. Such a man may be unable to achieve full potency and will excuse himself by saying, 'I couldn't bear to hurt her'. These anxieties may hamper enjoyment in intercourse—or even prevent consummation.

2. The social and emotional roles of man and woman.

To achieve maturity, both sexes have to find a way of balancing the bi-sexual elements in their make-up, and perhaps the most important factor in this process is the ability to identify with an acceptable model of an adult sexual person of the same sex—normally a parent. When there is difficulty girls may become either angry about their feminine characteristics or uncertain of themselves as women, and show these feelings in many ways—by limited or conditional enjoyment of intercourse, difficulty with bodily feminine functions or the social feminine role, and attacking themselves or their partners, or being the victim.

Boys who are not able to own and enjoy their own masculinity may see women as demanding too much from them sexually, and retreat into compliance or a sulky refusal to be potent. Marriage is seen as a 'take all' and 'give nothing' situation. They cannot identify with a sexually potent, nor-

mally aggressive father and so are afraid of the consequences of asserting themselves.

3. Ties with other important people, especially parents.

It is difficult when the child-parent relationship has contained too much resentment and frustration, for the child to leave the parents without a feeling of guilt. Then a vicious circle is set up because the young adult bitterly resents the hold the parents seem to have, although it may be of his own making. In other words, the relationship, has to be good enough if it is to be broken without too much distress.

For example, a girl who idolised her mother was eventually able to show her irritation that mother never had quite enough time for her. This complaint was the very one the patient brought about her husband. When she could put it back where it belonged, she was able to relate to her husband as himself rather than as if he was her mother all over again.

The young couple, before or after marriage, face the next series of 'life crises'—those of the child-bearing years. Inevitably, the GP is involved in the many medical events—pregnancies planned and unplanned, contraception, infertility, and enjoyment or frustration in sexual intercourse, as well as the management of childbirth and the puerperium. His attitude to these new experiences is again bound to influence the patients and may set the key to their whole future.

We went to our doctor when we got back from our honeymoon because we couldn't manage it, and he said to take me out and give me one or two drinks and we'd be all right. We did try that—(the patient winces)—but it was no good, so we didn't go back. That was two, four, eight years ago, and now I'm over 30 and do so want a family.

I told my doctor I didn't get anything out of it, but he said lots of women are like me, so I've just put up with it all these years.

The GP is often the first person to get to know of a triangular situation and in the middle years of life he may be called upon for 'picking up the bits' duties in the marriage relationship. Here again he may be able to help the couple to sort out reality from phantasy in the marriage. These inner conflicts in the marriage are related to the personal private world images and expectations that each partner brings to the marriage, and which have to be matched or balanced if the marriage is to become an

on-going reality, and also to the ways in which each partner sees the other, not as a real person, but as a figure in their own inner world.

All through life there are the emotional reactions to physical illness or necessary operations, especially those on the genital organs, such as prostatectomy or hysterectomy. The general practitioner is usually the only one who can assess what these interventions mean to the patient and quieten some of the hidden anxieties. 'This trouble is not due to cancer like your mother'; or, 'Perhaps you feel you have never been very good as a woman and that the surgeon taking your womb away is all you deserve'. 'Is it all right to make love at our age, doctor?', is a question he may also have to answer—whether asked directly or under some guise.

The GP is in the family at times of serious illness or death of any members. Here again he may be able to help by allowing the expression of both grief and resentments which may have to be denied to the outside world. A girl who presented in the Marital Clinic complained that she was no good to her husband, but her real difficulties soon became clear—that she needed to be helped to mourn the recent death of her father.

The question before us today is, 'Should the GP act only as a clinician and hive off the personal problems of his patients to the psychiatrist, trained social worker and voluntary organisations?' I would rather ask, 'Can he hive these off?', or perhaps, 'At what stage can he do so?' I suggest that every clinical symptom, from toothache to coronary pain, carries a psychological as well as a physical implication and that the psychological factor is of predominant significance in disturbances concerned with sexuality. So that the GP *is* involved with the patient's feelings in these matters, whether he will or not, but he is entitled to reserve the right to decide *how far* he is prepared to become involved.

But the privacy of the patient's emotional world must also be respected. It is not the doctor's job to decide whether or not the patient can deal with his own problems. The doctor's job is to be available. The minimum degree of involvement with which the GP can get away must cover the phases of attitude, recognition, and diagnosis. In psychological problems diagnosis and treatment proceed together and the GP may well find that when he has reached the stage of making a diagnosis he has, in the process, treated the patient.

Attitude: The patient can reveal deeper anxieties only when he or she finds that presented complaints are respected. So the first phase requires the development in the doctor of a specially skilled kind of listening, which includes accepting what is told without making a moral judgment about it. This listening requires sensitivity to the patient's unconscious as well as conscious communications, and some ability to move between the inner and outer worlds.

But it is not only the facts that patients bring which have to be accepted. Sometimes it is even more important to accept the reality—for the patient—of his phantasies. It is only after we have accepted them that we are in a position to demonstrate that these phantasies do not necessarily correspond to reality.

Recognition: While patients sometimes present their sexual problems directly—'I am impotent, doctor', 'I get no feeling at all', etcetera—very often they can ask for help only indirectly. The 'offer' may be made in many ways beside a direct appeal for help—by bringing a child to the surgery although nothing seems wrong with it; by repeatedly asking for home visits; by complaining of a symptom without any of the appropriate physical signs, ('I always get a backache at the week-ends, doctor'); and, especially in women, by repeated genital symptoms such as painful periods, miscarriages, inability to make use of any of the usual contraceptive methods—all without any signs of disease.

One of the most important tasks for the GP is to sort out the complaints at this stage and to recognise the sexual problem underlying the patient's 'offer' to the doctor, for only if this is done can he avoid giving the right treatment for the wrong condition on the one hand, such as sending his patient for hysterectomy without realising that the menstrual disfunction causing heavy bleeding was a reaction to an unbearable situation between husband and wife, or on the other hand, giving the wrong treatment for the right condition, as hymenectomy for non-consummation. The hymen may be excised, but the fear of painful defloration remains untouched in the depth of the patient's feeling until it is brought out into consciousness by verbalisation.

Diagnosis: It requires skill both to pinpoint the physical difficulty—which will almost always be found where there is marital conflict, and to find out what kind

of impotence or frigidity is present—and to understand these in the context of the emotional difficulties which go with them. These are connected, as I have suggested earlier, with conflict about the sexual roles in life, and complicated by feelings really belonging to earlier unsatisfactory relationships.

For example, Mrs A. said: 'I want him just to cuddle me and for there to be nothing else afterwards'. She was a girl with an unhappy childhood, whose chief memory of her mother was of being beaten by her. When it was pointed out that the need to be cuddled by her husband was the same need that she had as a small girl to be cuddled by her mother she said, 'and I want, to sit in his lap sometimes'. Naturally, Mr A. resented being expected to be mother to his wife, and certainly wanted there to be 'something more' when he petted her.

Treatment: There is a particular area of women's phantasies which can be explored during the vaginal examination. If we can get the patient to tell us, while we are examining her, what her own private picture of her genitals and the role of her genitals in intercourse has been, we can help her to find for herself whether this is founded on her own childish ideas which differ from the facts.

If these preliminary steps towards clarifying the situation are not enough to help patients to overcome their difficulties, an attempt has to be made to understand with the patients the patterns of behaviour with which they react. This understanding is most likely to allow a change to occur when the same pattern can be demonstrated in three areas simultaneously:—

1. In the patient's present life in relationship to people emotionally important, and particularly the spouse;
2. In the relationship with the doctor;
3. In childhood, in response to parents or siblings, or other important figures.

A man who felt his mother never considered him as a person was unable to have intercourse at the times his wife wanted it, and on several occasions came very late for his sessions. After these three facts had been linked together as showing his response to women whom he felt to be in authority, he was able to express some of his aggression to the therapist more directly and did not need to do it by missing part of his session. This was the first step towards

changing his attitude to his wife's needs.

When these behaviour patterns become obvious in the 'here and now' of the situation with the therapist, it may become possible to discuss with the patient the barely conscious reasons which underline their responses.

Many marriage problems are helped most easily when each partner is seen by a different therapist, and treatment in both cases is focused as far as possible on the interaction in the marriage. The emphasis is on what they do with each other, how they make use of each other to fit into their own inner worlds. When both partners are in treatment together it is possible for improvement to occur because of even a very slight shift towards better understanding as there is a strong force for growth and development inherent in the marriage relationship.

Referral: How far the family doctor wishes to go himself in treatment of these problems is a matter of individual choice and available time, but it is essential to attempt a diagnosis of the problem, even if the case is to be referred elsewhere. Apart from the help available from the psychiatrists, some special facilities exist for these cases. Many family planning clinics can help with problems which arise mainly in the woman's relation to her own body, and some centres have special sessions for marital problems for both men and women. Many probation officers are trained to help in marital cases. In London there are units at the Tavistock Clinic and the Cassel Hospital for marital problems.

Training of the GP: Many of us are painfully aware that our basic medical training does not give us much help in treating our patients' emotional and sexual problems. This is not something that can be acquired from textbooks or lectures or any formal teaching. The skill can be developed only by a study of the doctor/patient relationship in actual cases under treatment. This study can best be made in the atmosphere of a seminar group such as those started by Dr Michael Balint at the Tavistock Clinic, where the participating doctors are gradually able to allow some changes in their own attitudes towards more insight and flexibility, so that their own reactions to their patients can be used constructively rather than followed unconsciously.

I BALINT, M. (1957). *The Doctor, His Patient and the Illness*. Ch. XVI. London Pitman Medical Pub. Co.

Discussion

THE CHAIRMAN: Whether we believe, like Dr Emrys-Roberts, that we can hive it off, as he put it, or, as Dr Pasmore has said, we have to readjust our attitude, the fact that these cases occur is inescapable for all of us. The point is, how do we begin to deal with it, and how far should we go? Many of these answers depend on us as individuals, and will continue to do so. How many of us can be expected to involve ourselves with Dr Balint's seminars? That also is a decision we have to make for ourselves.

At the beginning Dr Pasmore told us that she was not going to give us any statistics. That is a pity because we do not know how successful are Dr Pasmore's therapeutic endeavours compared with those of us who perhaps shy away from them. This is where I have always felt there is a need for Dr Pasmore and others to give us the facts to show us that they can do something more with these ever-demanding problems than perhaps some others of us who are not so experienced in dealing with them.

DR E. GANCZ: The main problem in family doctoring is to get to the truth. That applies also to marriage. Very often the truth is missing in the sex life of married couples. I shall refer to one case I saw quite recently when I had to attend a patient of 62 with rheumatoid arthritis. I had to pull his socks off against very violent protestation. To my amazement, I found that all his toenails were growing into the soles of his feet. I turned to his wife and said, 'Why did you allow him to get to this stage?' She said, 'I didn't see it.' I asked, 'You didn't see it?' and she replied 'No.' I said, 'Have you never seen your husband taking a bath?' and she replied, 'Oh no, doctor.' They had been married for 35 years and neither of them saw the other naked. That is a far cry from the present day idiom of a double bath.

If a patient comes into the consulting room with her husband and the husband takes the chair, so to speak, and says, 'My wife is very tired; she has pains here, and there,' having been in practice for so long, my mind immediately asks me, is there some trouble between them in their sexual existence? We know how often this subterfuge is used to avoid sexual intercourse. I make a point, once I know that there is trouble, of not seeing them during surgery hours. I give them an appointment either before or after

surgery and I find myself spending three and a half hours trying to get at the truth.

DR R. L. MEYRICK: I wonder if we are being a little moral about this whole matter? It seems to me that what Dr Pasmore told us depends very much on our sincere belief, in this civilisation, of marriage. Under one of my 'hats' I attend a mother and baby home and what has impressed me is the way in which so many of the girls in mother and baby homes seek the right partner to fit the type of problem they have, neurotically or otherwise, created or had created for themselves. When they have found this partner, and it may take them 8 or 9 pregnancies to do this, they settle down to what may not be accepted in law as marriage but what in common law is marriage, and find a very stable situation. I wonder if the kind of therapy we are busily engaged on in reconstructing some marriages is the sort of relationship we should properly be aiming at.

I think we can teach medical undergraduates quite a lot. We tend to assume that medical students will pick up the necessary information from social contacts. Some do and some do not, but the vast majority have little idea of the range of sexual behaviour and the problems associated with it. A straightforward course included in the medical curriculum should be perfectly possible.

DR M. E. M. HERFORD: Are we not starting too late; why wait until they are medical students? One of the most important areas of medical practice today is that of the School Medical Service. H. G. Wells once said that 'learning was a small candle in a dark world.' Learning is spreading, but we need greater maturity. For medicine and for education three things are vital if people are to lead reasonable lives. A man has to come to terms with his disabilities and learn to live with himself. He has to know how to be, within certain limits, his own doctor. He has to know how to use a doctor when they meet in the disease situation. Education and medicine are indivisible, we can talk about organisation, but we have to have an idea of the principles and philosophy of practice or organisation is ineffective.

The School Health Service should attract the cream of the medical service. If I may quote another saying, Plato said that no nation could call itself civilised

until teaching was the highest profession in the land. If we are to have an interest in the family and the mother/child/parent situation, we must take a vastly greater interest in the educational sphere. Then, perhaps, we shall get young doctors and students better oriented towards medicine and better able to understand some of the problems and when the doctors go out they will find patients better able to approach them.

THE CHAIRMAN: What are your views on the future of the School Medical Service? You say that medical practitioners should be involved in it. What do you say about the future in this respect?

DR M. E. M. HERFORD: As I said the School Health Service should attract the cream of those in general practice. It should be a form of specialisation within the field of general practice. I use the analogy of medicine in industry. If every GP followed his own patients into their place of work the manager would be driven mad by a multiplicity of doctors. A firm, like a family has an entity, a biological life of its own and needs a doctor who understands the situation.

In the school the same should happen. The school has an emotional effect on the child which is sometimes quite frightening. If a doctor in a team of general practitioners specialised in the School Medical Service, he would be responsible for the health of the child in school and could feed back to the general practitioners responsible for the family what might be the effect of the school. He could report back and they could collaborate as a team with the teachers and other social workers.

Education helping the patient to come to terms with his troubles is central to the future of the general practitioner. This must start in the school form and nursery stage and link with the family.

DR M. J. F. COURTENAY: I should like to say a few words about figures. Dr Pasmore had to deal with the internal world and I know that it is unsatisfactory to try to deal with that in a statistical paper, but I have been involved in statistics of this kind before. The hell of it is to find controls.

Most people with symptoms of this kind get better in about five years. Recently

Malan¹ and others have thrown suspicion on the idea that no longer complaining of symptoms necessarily means cure. This is another hazard. The involvement idea was that you could show a change in a short time which was compared with what was thought of as a reasonable cure rate of five years. If anyone can show how to do control studies of these things, I shall be grateful.

¹Malan, D. H. *et al*, *British Medical Journal*, *Psych.* 114, May 1968.

MISS GWEN PADFIELD: I support what has been said about health education being an essential part of basic education.

I want to draw attention to three points in Dr Pasmore's paper, as fundamental principles in the whole of our discussion today. On her declaration about the terms used for a general practitioner, as a public health nurse the term 'family doctor' is always very endearing to me. The comments she made about attitudes are of extreme importance. If we paid more attention to attitudes to old age changes and so on and to co-workers, we would not have many of the problems we have at the moment.

A term which rankled a little was that of 'hiving off' because in this question of contacts we are talking about passing on personal relationships. That is deplorable because in team work among doctors, nurses and social workers, the patient, or client, is the central figure and there can be no handing over of this personal relationship. That brings me to the importance of attitudes because sometimes such phrasing tends to create resentment. We should talk of enlisting the help of the specialist.

DR JEAN PASMORE: I would like to mention the question of teaching undergraduates. Of course I agree that this is vitally important, but it seems to me that the essence of the kind of work we are talking about is that it is a two-way process, a two-way relationship. To teach it means involving the undergraduate or the post-graduate in evaluating not only the patient's problem, but their own part in the interaction between the doctor and the patient. This interaction, I do not think can be taught by formal teaching; it has to be developed in an atmosphere such as the seminar atmosphere in small groups.

THE LONELINESS of old age is a very large and complex subject, and I must confess at the outset that many of the answers are not available. We do not know enough about the underlying causes which have produced this increasingly common phenomenon, nor do we have sufficient understanding of the effects of current social changes. It is obvious that until we have a good understanding of causes our remedies will be inadequate, and this is the position we find ourselves in to-day.

This is not to say, however, that we should not try to reach a better understanding of loneliness. The dictionary defines loneliness as 'having no companionship', which is an oversimplification. An alternative definition is 'dejected by the consequences of being alone, or having a feeling of solitariness'. The second definition is much better since it includes the idea of a subjective aspect as well as the objective one of diminished companionship. Thus loneliness depends not only on how many social encounters the individual experiences, but also on how isolated she feels herself to be. Hence we deal with a large spectrum of differing individuals in differing circumstances. At one extreme we have the hermit whose desire to belong is almost zero. He sees no one, but he wishes to see no one so he is not lonely—he may, indeed, be very happy and content. At the other end of the spectrum we have the gregarious extrovert—with innumerable family and other contacts and living a very active and varied social life. When this type of person becomes old and frail and is unable to continue to manage her previous social round, she may feel herself to be lonely and cut off despite the fact that by ordinary standards she still has an impressive variety and range of contacts.

It is therefore essential when considering this matter to deal with each case as an individual. It is unforgivable to apply one's own standards in deciding whether loneliness exists. It is unnecessary to emphasise that it is even more unforgivable to take steps to combat loneliness which only exists in the eyes of the observer.

There is probably more loneliness among old people to-day than ever before, and the reasons for this are complex. One simple reason is the demographic one that there are more old people than ever before, both proportionately and absolutely. Simultaneously there has been a decrease in the number of supporting members of

society, that is the younger and middle-aged members. These changes have occurred as a result of changes in birth rates and mortality rates, and their effects will continue for many years. Thus we have an increasing cohort of older people, not matched by an adequate cohort of younger ones who traditionally have supported the elderly when dependency supervened.

Other social changes have aggravated this problem. Thus we have the change in living arrangements for families with the marked swing away from three-generation living to the present emphasis on the nuclear family. This process is seen most acutely where we have disrupted tenement life in our urban communities, and have separated the different members and generations of families. The old tenements with all their ghastliness had one enormous advantage, and that was enforced propinquity. Because everyone lived all herded together in one building or in one street area, frequent 'dropping in' and frequent attention could readily be afforded to dependent old people from siblings, offspring, nieces and even more remote family members who were all living within minutes' walk. Thus when two-hourly attention was needed, it could readily be provided without unduly disturbing any other individuals. With the new physical separation of family members and generations this becomes out of the question, even when family willingness is high (as it still very often is). Other changes have had similar effects, e.g. increased industrial mobility, increased tendency for married women to be in paid work (and hence not available for parent care when needed). These are all evidences of 'social progress', or perhaps more correctly of 'economic or material progress', and yet there are badly affected victims among the frail elderly.

Similarly the phenomenon of compulsory retirement at a fixed age is in some respects desirable—because it means that the older worker need not spend his later years in exhausting toil, and because it also ensures a steady number of promotion prospects for younger people. But for many men retirement means a sudden and dramatic reduction in social life, and many are thoroughly demoralised by it. His reduction in income means that he can no longer visit his club or pub, or if he does he may be embarrassed by his inability to stand his round with the rest.

Dealing with Loneliness in Old Age

Dr J. Williamson

Lastly we have the generally negative attitude of our society towards ageing and the elderly. We seem to be experiencing a cult of youth, and, of course, this means a rejection of old age. Many people see old age only as the absence of youth and refuse to think about it. It is one of those things which only happens to others. Our own profession is culpable in this respect. There is no instruction in the care of the aged in most medical schools; geriatrics is regarded as an unpopular and unrewarding speciality, despite the fact that all health workers are increasingly going to have to deal with it in the future. A pitiable proportion of finance and medical manpower is allocated to it, and where research is so urgently needed, we have neither the money nor the staff to do it. As general practitioners, you all know the difficulty of getting an elderly patient into hospital. How often have you heard the first question 'How old is she?', which certainly ought to be of no importance in assessing urgency. Again and again we hear hospital specialists talking of their 'blocked' beds. We know that medical students see and hear these things, and can we be surprised that they leave medical school believing that somehow it is someone else's job to look after old people, not really a job for a doctor at all.

Now I have paraded before you my woes and prejudices in trying to indicate why old people increasingly get lonely and miserable. What can be done about this? First, we need more and better research to determine causes; this is a theme to which I continually return.

Then, as doctors we have a special responsibility for old people's health, and where ill-health and disability is limiting an old person's ability to get out and meet others, it is an important cause of loneliness. Possibly to secure optimum general health is the greatest thing we can do to combat loneliness in our old patients. This means, in my opinion, developing special surveillance methods for old people (or at least for the high risk groups). But I cannot deal in detail with this subject to-day.

Locomotor disorders due to foot trouble or arthritis of hips or knees will make loneliness more likely, as will cardiac failure or dyspnoea due to respiratory disease. All these conditions can generally be greatly alleviated by appropriate therapy, especially if detected at a reasonably early stage. Dr Gancz spoke with surprise of an old man whose wife had never seen him naked. I might equally express surprise that Dr

Gancz had never seen this rheumatoid patient's feet before. This is not a criticism of the doctor because he did point out that he was called to see the patient. This emphasises my contention that if you wait until you are called, your own toenails may be growing into your feet!

Psychiatric conditions predisposing to loneliness are wellknown and are common, but despite this often go undetected till a late stage. There is dementia which requires very special measures for its early detection. Thus we must use health visitors to find these cases at an early stage. Then there is depression, and even if I cannot do anything else I would be glad if you remember this and think of it every time you hear of an older patient who is not managing so well. It is a common condition—in our 'early diagnosis clinic' we found 14 per cent of attenders to have this condition. Treatment of depression in the elderly has been shown to be more commonly effective than in younger age groups.

Thus I make a strong plea for special surveillance of high risk groups of old people—those living alone, those recently bereaved, those recently in hospital, etc. At the present time we in the geriatric service are examining these groups, but I have no doubt that this is something that the good general practitioner is well able to undertake, especially if he has had some training as a student in geriatric medicine.

There are, of course, social measures which can be taken to relieve loneliness, and the general practitioner must often be the person to initiate these measures because he is the one to whom the old person will look for help. Where the family is available and willing, loneliness will be rare, but not infrequently the old lady will not ask for help from her son or daughter, but may instead behave irrationally or become very demanding. It is then up to you to explain to the daughter why this is occurring, and often thereafter the need will be met. In my opinion you can only do this by explanation and persuasion, and there is no place for striking moral attitudes and hectoring relatives about where their duty lies. In my experience this paternalistic admonition only hardens resentment and does no good at all.

Outside the family, can we enhance social support for the elderly at other levels? Why not at street level? Many of these old ladies have helped younger women having their babies, many have helped with nursing care in other households for temporary illness

(or more often for terminal illness). This is the sort of mutual help which has been so effective in the past. Is it not possible to reactivate some of this potential? There are people in the street of good will, some of them owe debts of service to your old patient—how can we bring the need to the notice of the willing helper? You as general practitioner may be the ice breaker. How much more possible this would be if you were working from health centres with domiciliary nurses and social workers with responsibility for a whole defined community? The good health visitor will know everyone in her streets and ought to be aware of need. If she is working alongside the general practitioner, this is surely the ideal arrangement.

Other agencies can help—churches and voluntary organisations, such as old people's welfare committees. If there is not an old people's welfare committee in your area, you should start it or at least bully someone else into doing so! The voluntary organisations are full of good will and bustling with energy, but often their efforts are misdirected. If the general practitioner will only establish contact with them so that he can tell them where the need lies, then a much greater return can be achieved. He knows which old person is housebound, which is blind and needs a wireless or someone to read to her.

Why do trade unions not take a wider interest in retired members? They used to do more welfare work, and now when the need is greater than ever, they seem to be adopting a narrower, almost legalistic role. They should try to make retired workers feel that they still have an honoured position and are not just cast offs.

Mr Teeling-Smith mentioned the paternalistic employer. Here again is an opportunity for employers to show that they have moved with the times. Some family firms show a continuing interest in retired employees, and this could be copied by other firms. Big firms should do research on this, using skilled sociologists to help them. Japanese industry (not noted for its backwardness) plays a very effective, if paternalistic, role in this respect.

Television and radio are of great importance to us all in our daily lives, and for an increasing number of old people they play a dominant role in combating loneliness and isolation. Could we not have special concessions for smaller licences for pensioners—or waive them altogether? Programmes should be specially planned for the elderly,

both for entertainment and for health education. The BBC has only lately introduced a special programme of continual pop music for the teenagers. Would it not be more rational to have a continual old folk's programme since their needs are so very much greater and their dependence on broadcasting also so much greater.

Could the GPO provide cheap telephones for old people living alone? They would then know that they were not cut off, but could get help if needed. It would only be a rare occurrence to have to use the 'phone in an emergency, but the reassurance would be great.

I have tried to indicate the complexity of these problems, and I conclude by saying that I believe the general practitioner has a unique opportunity to study them and to do research. He can observe his patients in middle age as they advance into the senium and he can help to answer some of these questions.

Dr Emrys-Roberts who entertained us with his Celtic verbosity, perhaps unwittingly posed to us the stark controversy which underlies general practice to-day. This is the clash between those who would make you a purely scientific person—a technologist, and those who would emphasise your pastoral role to the exclusion of your scientific function. Dr Roberts would like to do 'clinical medicine', and so would we all, but in general practice to-day this is not enough because your patients are going to demand from you help with their emotional, psychological and social difficulties. If you refuse them this help, then you may be able to concentrate on your 'clinical medicine', but you will lose the status the public are according you as 'family doctors'.

If medical students were being taught to deal adequately with these aspects of medicine, then they would not feel so frustrated when called upon in this way.

I hope that general practice will survive, but I am convinced that it can only do so by broadening the scope of the work; any narrowing of the role of the general practitioner will be fatal to general practice as such.

Discussion

THE CHAIRMAN: Dr Williamson, with his customary clarity and ability, has brought out common sense remedies, especially about telephones and other things. It

sounds so simple, but we are apparently not doing it. He has a simple way of getting the good will of do-gooders so that they do all the nice things for old people. But there is no one to do the nasty things, such as those concerned in Dr Gancz's problem about toenails. I cannot see many of the nice women up the street getting to grips with the problem of the toenails, but perhaps they will.

The problem is that old people are sometimes difficult. The recent furore over *Sans Everything* did not appreciate that many old people are difficult to deal with. I should like to see some medical people put into the position of nurses in this difficult situation. There are many relationship problems which are difficult to solve.

DR J. J. MCMULLAN: So far this morning we have managed to keep away from politics, and I hope that we shall continue to do so, but there is one fact with a political and economic connotation which I think must be introduced in discussing loneliness among old people. It is one which Dr Williamson only touched on when mentioning the destruction of tenements and the isolation which that causes. The tenements have been taken away and housing estates put in their place, thus separating families. Any general practitioner must know that there is still a great deficiency of proper housing for old people.

Living in big houses unnecessarily, not having sufficient bungalows and welfare homes and not completely integrating schools and houses for younger people, has made it not possible physically to maintain the independence of the old person in the community. It is the job of us as doctors to demonstrate the facts and bring them to the notice of the public and of politicians. That is all I say about politics, but I do not think it should go unsaid. We are like Mrs Partington, trying to keep the ocean back with a broom.

We could go on talking about the geriatric problem all day. I want to hark back to something which both Professor Alwyn Smith and Mr Teeling-Smith said earlier. I introduce it by telling the story of a friend of mine who, a few years ago, told me that his father was thinking of buying a new car. At that time this friend's father was in his late seventies. He was asked, 'Why don't you have a Rover?' and he replied, 'On no. That is an old man's car'.

Something came through to me from what Dr Williamson and Professor Alwyn

Smith have been saying. Perhaps we can do these things to people and they allow them to be done, but is it not much more important to create the attitude of their coming forward and asking for them to be done? Perhaps this would prevent Dr Gancz's old gentleman allowing his toenails to grow. He might have asked his wife to cut them 30 years ago, if he could not reach them himself.

Is it true to say that self-reporting of illness will not be relied on 10 or 20 years hence? With proper education, the younger people, who will be old then, ought to know what to look for, it is suggested, but I am very afraid that they will not know what to look for. They will get palpitations and write to the National Heart Hospital to be put on the list for a heart transplantation. This is an extreme parody of the situation, but I wish that the mass media could be encouraged to put across ideas which are informative and not alarming. We know why at present it is alarming—because of the news element—but the climate could be changed. The Charter of the BBC is to inform, educate and entertain; nowhere does it say that it must alarm. I think that sometimes, in competition, they have tended to introduce alarm to situations.

The position, I am sure, is improving, but will we perhaps be able to influence the mass media to move in the direction of giving people sensible information which will tie up with school leaver's needs and help people in their working years to plan their lives ahead and be able to meet crises as they come along?

DRE. GANCZ: Thank you, Mr Chairman, for giving me the opportunity to congratulate Dr Williamson. I never had an opportunity of looking at those toes. This was not an isolated family affair. The woman would not see them. Eventually, in exasperation, the wife called me in against her husband's objections. When I saw him he had rheumatoid arthritis with acute inflammation of both hands. He was still going to work and his job was in a factory filing with his hands. They had two children. When I asked the wife why they had never seen each other naked, she said, 'It is not nice, doctor'.

This is the age group which still believes they cannot have anything without paying for it. They are the people who still go to a doctor outside the Health Scheme paying for consultation, or even offering to pay within the scheme. I am sure we have all had experience of these elderly people who

try to give you half a crown or more for going to see them. This is why these people eventually develop lonely geriatric problems.

MISS G. PADFIELD: I want to underline the point I made before about the importance of attitudes. I have done a lot of work with and for old people. I am convinced that until we change the attitude of ourselves and the general public to growing old these difficulties will continue to arise. For example, we all know that the general conception of old age is one which involves people who are poor, lonely or sick. None of these situations need arise if we act in time.

In regard to health education in this context, if people from the time they begin to be educated learned more about biology in normal teaching, to some extent this would change the attitude to old age. It is considered a crime to be old, whereas it is actually an achievement to get over life's hazards and grow old. Many people say, 'I dread the idea of getting old'. They seem to forget that the alternative is to die young—and who wants to die young?

Old people are difficult, but why? Is it because they have not had enough vitamin B or C? We know that many of the so-called cases of senility are cases of malnutrition in reality. Problems of old age are so enormous that we spend all our energies dealing with problems which have already happened and have not the resources to prevent them happening in future.

DR A. GILMOUR: I should like to follow some things which Dr Pasmore said because I think them extremely relevant. From my past experience in General Practice I believe that in many cases the difficulty of the old person is that, after being a fighter throughout life, he feels that by ceasing to fight he will cease to live. One has to contend with this human attitude. I was horrified, when attending old people in large institutions, by the complete indifference of many of their families. This, I think, occurs from a wrong understanding of the Welfare State and the idea that there must be some organisation to deal with this situation rather than a sense that the community is responsible, and this means the individual has a responsibility.

As Dr Williamson suggested when speaking of the village community, the fact that an individual cares or bothers about an old person is a greater relief to his loneliness

than any amount of organisational provisions. So much of this becomes a matter of education of the whole community in the proper part it should play.

The attitude of young doctors is very important also. There are so many vicious spirals in the vicious cylinder. Old people are 'blocking beds'; they are in the wrong beds because the right beds are not there. The junior hospital staff perhaps do not understand the problems of the old people and the best way to deal with them. Vulnerability in re-housing has many complications. The old, the young and the intermediate suffer, and perhaps the most vulnerable is the GP because of the break up of the family unit.

So many needs of old people do not get proper attention, not just because there are different authorities dealing with them in different parts of the Health Service, but because of hostility and competition, which leads to bickering instead of co-operation. This again is something where a special form of education is necessary.

DR D. ROBINSON: Both the last two speakers have mentioned education. No matter how you educate people, old people compared with younger people are that much nearer dying. In spite of the banality of that statement, there is the fact that if you are that much nearer dying, you are likely to relinquish and others are likely to relinquish with you, all kinds of things, emotional, social and financial. You are a 'bad risk' at all kinds of level. One of the few positive roles left for an old person to play is that of being ill.

DR J. T. WOODALL: The problem which Professor Alwyn Smith posed is how are we to find these people? We cannot rely on their coming to us. One of my partners, John Paulett, had done this by means of employing an educated woman as an ancillary worker, to go round making functional inquiries.¹ This does not require a nursing or medical qualification. She can go to old people and find how far they can get from their front door, how often they are visited, whether visitors come by foot on a simple journey or a complicated journey across country, whether they can hear the radio or see the television, whether they have toe nails sticking into the soles of their feet, or whether their joints are moving. This is a

¹ John D. Paulett *et al*, *British Medical Journal* (1969) *1*, 432.

help in finding people who are lonely or about to become lonely.

My second point is about housing. In my area there is a sheltered housing community. There are some elegant bungalows with nice flowerbeds in front of them, but there is no through traffic. The only traffic in and out is the hearse. There is no special provision except a part-time warden who clearly cannot nurse these people. Dr Paulett has been trying to persuade people in authority to encourage those who are still mobile to leave the area and build it up into a brighter community place with full-time day and night nursing, laundry facilities and so forth for disabled people who do not need to be in hospital.

Lastly when an old person is ill, after a stroke for instance, we have to accept that if they are to walk again they are bound to have falls. It is no good nurses filling up an accident book and sending for the relatives everytime they stumble.

DR P. HOPKINS: Loneliness, of course, is not the prerogative of old people. You can see a schoolboy in a crowded playground, or an adolescent in a dance hall who will feel lonely, and a housewife living in a block of flats with lots of others will tell you that she is lonely. This is a common expression of depression whether one is a child, an adolescent, middle-aged or old. I have been carrying out an exhaustive study of senior citizens in my practice in the last five years and I am astonished at the number of old people who say they are lonely, not according to the definition, but because they live with their families and feel that they are not wanted. As a family doctor, I feel a responsibility for preventing this problem in later life.

Another part we can play is in encouraging middle-aged patients to prepare for retirement so that they will have occupations and make friendships which will continue into old age.

NOWADAYS, MORE people than ever directly and openly approach their doctors for help with emotional problems, and many patients with somatic symptoms are really suffering from emotional illness. There are varying estimates of the proportion of such patients in general practice, ranging from 10 per cent to 90 per cent, but whatever the numerical estimate may be, there is general agreement that the number is not negligible, to say the least, and that the difficulties and strains produced by these patients for their doctors are greater than the sheer numbers indicate.

Medical men, especially general practitioners, are therefore willy-nilly involved in problems of mental ill-health. To what extent doctors are willing and able to help emotionally sick people or even to accept the existence of and to recognise emotional illness, will depend largely on the climate of medicine at the time. Today, the climate of medicine is one that was created 100 years ago: we are in the era of scientific medicine. By that I mean that medicine is considered to be based on the natural sciences, both in method and content.

This outlook has led to unprecedented advances in medicine: epidemic diseases that used to be the scourges of mankind have been eradicated. The lives of untold numbers of sufferers have been prolonged, and lost functions have been miraculously restored. But in spite of the great advantages that humanity has gained from scientific medicine, modern scientific medicine seems to have developed in a manner that may be its own undoing.

Specialisation has led to a fragmentation of the specialists. The patient has become a conglomeration of minutiae that are studied in increasing depth, but in ever retracting breadth. On the other hand, the domain of practical medicine has been expanding as fast as scientific medicine has been contracting into specialisation. In spite of our conquests of disease, our waiting rooms and those of the hospitals are overcrowded with people who are clamouring for relief from illness, unhappiness, disfunction, and fear of death.

This contradiction and the recognition that scientific medicine is of little use for the study and treatment of emotional disorders has led doctors to look for other disciplines that would help to further the understanding of those states of illness that scientific medicine seemingly does not understand. The development of psychiatry in the last seventy years, especially that of psycho-

analysis, has led to a recognition of the importance of emotional factors and of their influence on physical conditions and general health. Medicine has also been forced to take note of the social nature of man. Sick people cannot be properly understood without an understanding of their family and group relationships and their cultural ties and habits.

Lastly, and more recently, it has been found that to understand properly the patient and the illness, the doctor has to understand and to study his own involvement with the patient. For this purpose the doctor ought to recognise that he himself is a measuring instrument which reflects and participates in the patient's illness and that, at the same time, he will influence the patient by the very fact of his contact with him.

A new climate of medicine is thus in the course of being created. Unfortunately, medical education has lagged behind this development and, although a good deal of lip-service is being paid to the concept of treatment of the whole person in his somatic, emotional, and social setting, the professional skills necessary to carry out such treatment and the relevant diagnostic tools are not being taught. In consequence, not only are important skills lacking in the doctor's equipment—skills that he needs to deal with emotional ill-health—but, because the concept of this whole person medicine is often devalued, as we have heard this morning in discussion, if only by implication, many doctors are quite unwilling as well as unable to deal with emotional disorders. Dr Walton, of the Department of Psychiatry, University of Edinburgh, wrote in a paper¹ published in the *British Journal of Psychiatry* in 1966:

'Many doctors are not equipped to treat emotional disorders . . .'

and

'many young doctors graduate with a distinct antipathy to the social and emotional aspects of illness . . .'

and further,

'Experienced general practitioners sometimes express strong dislike for the psychological component of their practice . . .'

So one way of dealing with emotional illness in our patients is to refuse to accept and deal with it. But is this really possible nowadays when the public at large is often well informed about the importance and relevance in medicine of emotional problems?

Providing a Climate for Positive Mental Health

Dr M. B. Clyne

What do I mean when I speak of emotional problems? Perhaps we had better look at some of these problems as they are being presented.

Let me quote two commonplace examples from my practice: A young woman had come to see me saying angrily that she was fed up with life and would either kill herself or her husband. He had been beating her up a number of times. She showed me bruises and abrasions on her face and arms. They had been married for six years. She had not been happy with him from the beginning and when he was sent to prison three years ago, she took the opportunity to obtain a divorce. Yet she visited him in prison, and when he was discharged she took him back. Whilst he was in prison she had led a gay life with other men, more for the sake of the monetary presents she gained than for the sake of sexual satisfaction. Ever since they had lived together again he had been beating her, had called her a prostitute and would not allow her to go out alone, although he went out every night until the early hours of the morning. She thought that he spent his time with girl friends, but whenever she accused him of this, he would beat her up. This had happened quite a few times and she promptly came to my surgery afterwards to show me her bruises, abrasions, and cuts, which were really quite bad.

The question immediately arises whether the problems presented by this patient concern the doctor. I think everybody would probably accept that treatment of the bruises and cuts belongs to the field of medical care, but what about the rest? By that I mean the symptoms and signs of emotional ill-health. Here we have a woman who sticks to her husband who repeatedly beats her up badly, a woman who asks for the beatings by provoking him, a woman who tells her doctor at her first meeting with him about her rather shady past and immoral escapades, thus presenting herself as a bad woman, and a woman who somewhat obsessively repeatedly shows the doctor her bruises and how she is being punished, as if she had to affirm that she was now paying for her immorality and badness.

The unhealthy relationship this woman has with her husband and the symptoms and signs I have described and which make her unhappy and hamper her proper social functioning, indicate that the woman is emotionally ill. In addition, the couple have three small children who are already show-

ing signs of emotional ill-health. This is the type of case of emotional ill-health where the doctor—all of us—has to decide whether as a medical man he should intervene, although there is little clinico-pathological material in this case in the traditional and scientific sense.

Another type of case is probably even more common. A married woman, 30 years old, came to see me and told me that she had been losing weight recently and had been coughing a lot. Could I arrange for her to have an x-ray? I examined her chest; there were no pathological signs, but after all, she had been coughing and losing weight and everybody knows about pulmonary tuberculosis and its major symptoms and signs, so her request appeared reasonable on the surface. I sent her for an x-ray of the chest and gave her some cough medicine. The x-ray was quite normal. I told her so and you might have thought she would have been satisfied, but that was by no means so and she bitterly complained that the cough had not got better. I gave a very strong cough suppressant and there was no cough left, but now she came back with pelvic troubles.

This made me rather suspicious and I tried to get her to talk to me about herself. It turned out that her husband was impotent and that he blamed her for it. In consequence she felt that something was wrong with her, as she obviously could not capture and excite her man. This anxiety, based on her feeling that her status as a woman was impaired or some element of her womanhood missing, made her ask for an x-ray, by which request she really meant: 'Please shine a magic ray through me and see whether there is something radically wrong with me as a woman or something is missing'.

If we accept the fact that many such patients exist who present either with overt emotional disturbances or with emotional disorder hidden behind seemingly physical symptoms and signs, the question arises: are we as doctors under an obligation to treat such people, do they belong to our or somebody else's professional realm?

I have already said that in spite of the brilliance and achievement of diagnostic instrumentation, operative surgery, pharmacology, and of the discoveries of biochemistry and biophysics that reach into sub-atomic levels, the great mass of illness, with its resulting loss of working hours, unhappiness, ineffectual living and suffering, like a ghostly enemy, does not yield to our

weapons, however refined and sharp they have become. If we doctors want to remain the masters of medicine, we need new weapons. If we are going of our own free will to omit a vast area of illness from our professional field, other professional workers will have to step into the breach thus created, and we general practitioners will indeed be left to deal with syringing of ears, signposting patients to the appropriate specialists, the issue of certificates and repeat prescriptions. On the other hand, if we regard the field of general practice as that of diagnosing and treating sick people in the totality of their somatic, psychic and social setting, if can we understand what makes a particular patient tick and use this knowledge to help him, then our work will be both humanly and scientifically interesting and important. The choice is ours—yours and mine. It lies between being a high-grade nurse or being physician to the whole man.

The next question is, of course, how are these people to be treated, and what should the aim of treatment be? Our medical training has instilled in us an attitude of centering our diagnosis and treatment on the illness. We have heard this this morning; people have been talking about illness and the prevention of illness. Perhaps I can illustrate what I mean by the case reports I have presented. I suppose if we were to ask a psychiatrically well-trained clinician for the diagnosis of my cases he would probably say that the first case, that of the woman who was beaten up by her husband, was one of hysteria with masochism and that the second case, that of the woman who wanted an x-ray, was one of an anxiety state. Does this really get us anywhere? The treatment would automatically follow from the diagnosis. Both patients would be treated either with tranquillizers or referred for psychotherapy, either to a psychiatrist or, if the general practitioner happened to be a well-trained psychotherapist as well—as does sometimes occur—by himself to himself. But there are certainly not enough psychiatrists for the enormous number of emotionally ill patients, and if general practitioners were going to apply formal psychotherapy to all of these patients, they would have no time left for general practice.

There is also the question, which is not unimportant, of whether the patients described and similar patients would be willing to undergo lengthy and formal psychiatric treatment. The administration of psychotropic drugs may for a time cover up the emotional turmoil of patients, but neither

this nor the wholesale referral of patients for psychotherapy would really be a useful contribution by the general practitioner to positive mental health. Perhaps we have to learn to apply in general practice an approach to our patients that is not centred on illness, but centred on the patient.

By this I mean exactly what I have described as whole person treatment or the understanding of the patient in his somatic, psychic and social setting. The question will be asked: if we doctors are to attempt to deal with emotional disorders, or try to understand the emotional motivation behind somatic symptoms, would we not be swamped? Is there time to look at people in this way?

Unfortunately, I cannot answer this question in detail now, but whatever objection to this outlook people may have, it has been shown that an approach that takes into account, both diagnostically and therapeutically, the total situation of the patient can well be carried out in general practice without the doctor being overwhelmed. Not every patient needs lengthy examinations and treatment both in the physical and the psychological fields. The doctor must always ask himself whether helping intervention is desirable and to what extent it should be carried out. The doctor may do something, very little, at a given time and leave the rest to the patient. If the patient is capable of maintaining a good relationship with somebody, the treatment of the patient's condition may be worked out by the patient within the relationship.

Perhaps I may briefly quote an example of what I mean. This case is so pungent that, although I put it sometime ago, I hope those who read it will not mind my repeating it. Some time ago a mother came to see me with her little girl who would not go to school. The child woke up every morning with a bellyache and felt sick. This had been going on for about six weeks. I knew the family quite well. In the past there had been sexual difficulties between father and mother that had culminated in rows between the two. From one of the efforts at reconciliation, a pregnancy resulted. A new baby had been born into the family a couple of months before the consultation I am talking about had taken place. When the mother had told me very briefly about the child's symptoms, I turned to the little girl and asked her to tell me about her complaint. She mentioned that her abdomen was getting bigger when she had these pains and, with my knowledge of

the background, I was able to ask whether she thought she was going to have a baby. Somewhat shamefacedly—and to the terror of her mother—she said ‘Yes’. It was fairly obvious that the child identified herself with her mother, that her belly-ache was symbolic pregnancy and that thereby in her mind she had taken over the place of the mother in a family. So, with these childish phantasies of being a little mother herself, of being as good as her own mother, and with destructive wishes towards her mother, she just could not go away to school and leave her mother alone because she felt that her wishes might really come true in her absence and that she might find her mother dead or no longer there when she came back. This very brief discussion, five minutes, brought immediate relief to her and her mother. It enabled both the little girl and the mother to adjust their relationship and to work through their mutual feelings within the framework of this relationship.

This brief example is no recipe of how to deal with emotionally sick people, and I cannot in this short paper give you such instructions. Medicine in its new climate requires specific skills and techniques as much as scientific medicine requires specific skills and techniques, and both have to be learned by study and application. A sympathetic ‘poor chap’ attitude, intuition, kindness, sympathy, or ordinary everyday human understanding are not enough and it seems a pity that many general practitioners, who wanted to achieve the highest reaches of their calling by being physicians to the whole man, had to do so painfully by hit-and-miss methods in the course of their practice at their own and their patients’ expense. Perhaps in future the skills of the new medicine will become part of clinical training and will be recognised as the most important part of education for general practice.

When such a climate of medicine has been created, we shall be able to think in terms of positive mental health, even in terms of positive health altogether, and we shall also be able to guide our patients by our understanding of positive health to their path to positive health.

There is, of course, no human being who is free from emotional problems. Even in the new climate of medicine we shall not be so ambitious, or foolish, as to think we could free people from all pain, from all anxiety, from all deviation of what we might stipulate as normality or health. But we would help people in the emotional turmoil

that is part of living and help them to obtain a state of functioning in which they could find both personal satisfaction and social acceptance, even though they may still need the occasional help of their doctor or other professional worker.

I WALTON, H. J. Differences between physically-minded and psychologically-minded medical practitioners. *British Journal Psychiatry*, **112**, 1097, 1966.

Discussion

DR J. CHAMBERLAIN: I should like to make a plea following up a point made earlier by Dr Fry. It is to have some scientific statistical evidence that this treatment of emotional problems does in fact work. I believe that it does but at the same time feel that individual case histories are insufficient proof. Some special study of this topic is needed.

THE CHAIRMAN: This came up, when Dr Courtenay said how difficult it is to carry out clinical trials delineation but the fact that it is difficult does not make it impossible. Like Dr Chamberlain, I feel that this is holding back what is good in the methods that Dr Courtenay, Dr Clyne and Dr Balint and others have shown is possible in general practice. General practice requires many different techniques and, as Dr Clyne has just said, it need not take a long time to acquire these methods.

DR H. J. CARNE: I get more and more depressed each time someone tries to talk to about us emotional problems and we are asked to provide statistical proof. How can you find statistics for human relationships? No one has said how that can be done. We live in a society where most of us are satisfied and healthy and where in a mature marital situation, the family and so on, is the right living unit—but who has provided statistics to show that? Can we not accept this with our emotional problems as well? Those of us who have tried it find it satisfying and helpful and at least some of our patients do. It is at least worth trying before we show proof. We do not have to prove everything.

MISS E. M. GOLDBERG: I am quite sure that Dr Clyne and his colleagues will have to go on helping people in the best way they can, but those of us who are inclined to do so may make some small attempts to evaluate these approaches. I should like to

challenge a statement we just have heard. Namely, that most people are satisfied with marriage and the family as they are today. These institutions are under heavy attack by many young people just now.

On what criteria can we evaluate treatment? Perhaps one has to begin in very simple ways. As has already been suggested a study of consultation rates and their content before and after treatment, is one possibility. Some criteria adopted for success or failure in the aftercare of mental illness may be misleading. For example, some people take readmission to hospital as a criterion of failure which may not be so, since good aftercare may lead to early detection of relapse and timely treatment.

Some researchers have taken simple behaviour indicators of success in treatment such as ability to work, to function adequately as mothers and housewives, etc. From these simple criteria of role performance we may venture forth into more complex measures of attitudes, feelings and relationships with others. What I am sure about is that the problem of evaluation should not be posed as an either/or question as to whether psychotherapy should continue as a form of treatment or not.

DR M. R. EASTWOOD: It would appear that there are four problems being discussed at one time: the evaluation of psychotherapy, the value of prevalence studies, normative data and whether there is a type of treatment which could be universally applied by doctors. Although we cannot discuss all these problems this afternoon in relation to what Dr Clyne and others have been saying, two points must be emphasised. First, prevalence studies have been carried out and in particular I should mention the study by the General Practice Research Unit at the Institute of Psychiatry.¹ It is clear that statistics can and must be applied to psychiatric illness in general practice, since without these neither research into this type of morbidity nor planning for service commitments can be put into operation. Second, although psychotherapy may be a useful form of treatment it does not follow that all doctors can apply it, since general practitioners are not selected on the basis of their interest in or understanding of psychiatry. It is important to know whether psychiatric problems in general practice can be managed in a universally applic-

able way, whether it be by drugs, social intervention or psychotherapy.

¹ SHEPHERD, M., COOPER, B., BROWN, A.C. and KALTON, G. (1966) *Psychiatric Illness in General Practice*. Oxford University Press, London.

DR J. WILLIAMSON: I should like to plead in support of Dr Chamberlain that we should strive to introduce a scientific basis into the pastoral aspects of our job. The conflict between the scientific fallacy and the pastoral fallacy is bound to be won by the scientists unless we can kindle some scientific spark. The fact that we do not have instruments at our disposal should sharpen our endeavour to get those instruments.

Miss Goldberg has questioned the statement by Dr Carne that the value of the family as the basis for the organisation of our society is so self-evident that we have no right to question it. As a specialist in geriatrics, I question that because I am continually forced to admit that we see unhappy old women and the reason why they are unhappy is that their whole social firmament is based on the family and when the family fails because of death, widowhood or dispersal, the old lady is bereft. There is no other strata on which she can operate. So we must question even such fundamental concepts as the basis of the family.

DR R. L. MEYRICK: I had hoped that Miss Goldberg would blow some fresh air into this matter. The question of mental health is one of whether the individual will survive in the community. Whether they survive successfully or not depends on the particular community in which they are living.

We must move from the back streets of London to the detached houses of Beckenham. To talk about the general practitioner being all things to all men—and to all women, it seems—is to take psychiatry and psychotherapy to a point at which no one can possibly practice it. My feeling must be that if you have an interest in this subject you will draw to you those who feel they benefit from you. Someone has said that the practice which you perform will attract patients reflecting your abilities. This must be so. If we accept that, there can be no question of statistics being applied.

I am sure that Dr Clyne's practice contains large numbers of people who are appallingly neurotic whom I would turn away from my surgery because my approach would be authoritarian. This may be my difficulty in this too liberal world.

DR M. J. F. COURTENAY: When I said it was difficult, I was not running away from the statistical evaluation of these things. I said it was difficult, but not impossible. I hesitate to go further because all this is in the melting pot. There is some evidence that the consumption of medical care is related pretty directly to the psychological disturbance of the people concerned. There is a tie-up with actual organic illness in all this. If you examine the people in your practice it may be one of the instruments which will help you to evaluate whether psycho-therapy is a useful thing or not. There is a further trouble built into the method of psycho-therapy, that the diagnosis is in fact starting the treatment. This is why the control situation is so difficult.

DR H. J. CARNE: Although I agree with Miss Goldberg that it is not an ideal state, I also accept responsibility for choosing a bad analogy but those who are happy in marriage accept this without wanting statistics to prove it. Those who are helped by psycho-therapy find it satisfying and helpful. Let us go ahead and treat these patients in this way without being kept down all the time by people wanting proof and statistics from us.

DR P. HOPKINS: The 'either or' comes time and again in medicine. We are either authoritarian or submissive, but as general practitioners we should be both. Unlike Dr Meyrick, who admits courageously that he is always authoritarian and therefore cannot tolerate a neurotic patient, is there a sop for you and your patient because people come to us for help? If a patient comes with cancer in her breast, I have to be very

authoritarian and get her to see a surgeon. I do not want to get into an argument about long or short interviews because we can all occasionally find a patient on whom we can make an interpretation in a few minutes. It is interesting that Dr Clyne has to think up an old story for something which happened quickly!

On the question of criteria and whether there is any point in insisting that students should learn about these matters or not, surely the patients can often be their own controls. There is the patient who goes from hospital to hospital and doctor to doctor and has all scientific tests and investigations and says he still has a headache, then goes to Max Clyne and he is back at work for the first time for three and a half years. We are either scientific or we are pastoral. Sometimes, surely, we have to be both.

Then there is the criterion of the patient who has got better 'because he does not bother us any more'. Patients have been known to say, 'It is no good going to a doctor because he is not interested in me.' The doctor thinks he has been successful, but the patient has gone to someone else. Surely the future general practitioner—I prefer 'family physician'—should be selected because he or she is interested in people and wants to help people.

THE CHAIRMAN: The point still is that we want to do what is best for our patients and until we know what is best we cannot do it. Obviously, there are more ways than one of doing what is best. However, it is an unresolved problem which will go on being unresolved for a while yet.

THE COMPLAINT of being overworked is uttered so frequently by general practitioners that it tends to be accepted without question, not only by the profession, but also by our patients. In sociological circles the euphemism for being overworked is 'workload'. Used correctly, 'workload' describes the time consumption and inter-relationship of the various functions carried out. Strangely enough, in medicine the term seems to be confined to general practice. We do not hear of the workload of a heart surgeon waiting for a street accident before he can carry out his next transplant operation.

Is this because the term incorporates the emotive word 'load'? A load is a burden. We say we are overworked. Our work is said to be burdensome. Hence we equate our activities with workload. In this paper I shall continue to use the term workload in its accepted form, but at the outset I want to state that I am not necessarily accepting the argument that general practitioners are overworked or overloaded. Indeed, I am reminded of the notice outside the sick quarters when I was in the RAF: 'Do not complain that you are being overworked just because it takes you half an hour to do a five minute job.'

Overwork—'my heavy workload'—is, anyway, a relative term. When we are enjoying what we are doing time seems to fly; when we are bored, time drags. All of us at some time have to take our share of the dull jobs. To do so for one afternoon, or even one day a week is acceptable. If we are asked to do so all the time, life would become unbearable for most of us. Our workload would be oppressive.

Another complicating factor—as Fry and his associates pointed out in 'Present State and Future Needs of General Practice'—is the split day of most general practitioners. Instead of completing his day's work in one go—be it a day of six hours or eight hours or even 12 hours—it is split into two, and sometimes more, parts. If we could start at, say, 9 in the morning and finish at 6 in the evening (an eight or nine hour day depending on whether or not you include lunch) would we feel less overworked—would our workload seem lighter—than if we worked (as many do) from 9 in the morning to 1 and from 5 to 8 in the evening—which is only a seven-hour day?

The factor of continuous responsibility must also be added to our workload. It is immeasurable in time, because it is always there. It has no end point. There are men—

and women—in other professions who also carry a continuous responsibility, but they have skilled assistants. Senior police officers who are always on call (even when on leave) will not be at the mercy of a crank who wants to get them out of bed in the middle of the night. An ordinary police constable will verify that the call is genuine, and vet the need for his senior to be disturbed. Our colleagues in the hospital service will only be called if their houseman or registrar is worried. The houseman or registrar may work long hours, but their tenure of office is—or should be—limited. The tenure of office of the GP goes on until he retires.

We spend a great deal of our time voicing our complaints, and writing letters to the journals about them. Would it not be better if we spent some of those hours—which so far have been wasted—in trying to work out a solution?

Of course general practice varies. My normal working day will be quite different from that of my colleagues in rural practice. Among the variables influencing the way we practice are:—firstly, the geography of the practice and, secondly, the class of patient—practice in South Kensington is quite different from that in North Kensington—and thirdly, there is the structure and facilities of the practice premises—are they designed for proper and easy examination of patients?—what ancillary staff is available?—who gets the records out?—is there a nurse?—and so on and so forth. Lastly there is the personality of the doctor—is he single handed or in partnership?—is he one of a proper group practice, sharing premises and staff?—are there branch surgeries? You will have noted that I included branch surgeries as a facet of the doctor's personality. In urban areas I have no doubt whatever that that is what they are. Indeed, it leads me to ask, how much more of the trauma of overwork is self inflicted?

Let us pause to look at some of the facts of our workload. The average list size in England and Wales is just under 2500. In this calculation the only time which concerns us is the time spent in actual contact with our patients. The time we spend—whether we are forced to spend it, or whether we do so voluntarily—on travel, on administration, on study and research; and the hours we spend waiting to be called out from our beds, are not relevant to our workload in the strict sense. They are relevant to our load.

How many hours a day do we spend with our patients? Six hours is a lot of time to

The Doctor's Control of His Workload

Dr Stuart Carne

spend in actual consultation, and I suggest that few GPs spend anything like that length of time on an average day. Two hours in morning surgery, two hours in the evening, and two hours on visits is a big programme, remembering we are not including travelling and waiting time. I believe most GPs spend a lot less than six hours per day in actual consultation time. Those who do consult for as long as six hours almost always have an above average list size.

Most of us work five days a week. We take half a day off during the week and we only do half a day on Saturday. Of course, to this we must add the time we spend on night calls and our share of week-ends. For those whose mental arithmetic is not up to it, six hours a day, five days a week, 52 weeks a year—comes to 1560 hours a year. Add another 240 hours for night calls and week-ends (that is over four hours a week spent on emergency consultations, not counting travelling) and we get a total of 1,800 hours a year. I have not counted holidays in this calculation because I have assumed a locum is available; though in a group practice he is probably unnecessary. Two thousand four hundred patients, 1800 hours—that is three-quarters of an hour each, 45 minutes per patient per year. This is almost certainly the upper limit. Most GPs consult for little more than five hours a day; and for at least one week of the year there are national holidays: Christmas, Easter, Whitsun and August Bank Holiday. These doctors have less than 32 minutes a year to offer the average patient.

It is necessary, at this stage in the calculation, to remind ourselves of the significance of this sort of arithmetic. We are talking of averages. Many patients—at least one-third—do not consult us at all during the year. Others come only once. Some come more times than those not working in general practice would believe. There is one child in my practice who was brought to see me by her mother over 100 times last year. That child had many hours of my time and so did the rest of her family. So also did the patients who were asked to book five or six half hour appointments to discuss their personal problems and anxieties. But the average patient gets between 30 and 45 minutes a year.

As the average patient consults his GP about five times a year, the average time available per consultation is six to nine minutes. Published studies show, in fact, the average to be just over six and a half minutes.

It is often argued that we have to rush our consultations in general practice; though when I look at some figures for the average consultation time in a hospital out-patient department (taking all specialities into consideration, not just general medicine) a six minute consultation in general practice does not seem excessively brief.

Suppose we plan to double the time; give each patient at each consultation an average of 12–18 minutes. How can we do this? We could get a 40 per cent increase in our consultation time if we worked seven days a week. We could double the number of hours we spend face-to-face with patients if instead of consulting five to six hours a day, we consulted 10 to 12 hours a day. We could reduce the average list size by half—but the population is going up, not down. We could increase the number of GPs—and we could spend the rest of today arguing that point. We could reduce the frequency with which the average patient consults us. That certainly offers possibilities, though I would hazard a guess, that the better the service we offer the greater the demand. And, of course, we can increase the time available by adjusting each of these variables—if they are adjustable to any significant extent.

In several practices a nurse has been attached full-time. It appears that she can save the doctor up to 18 per cent of his work. But is six minutes too short a time for the *average* consultation? Many consultations take far less. Repeat certificates, properly organised, need take scarcely more than a minute. So too the follow-up for an acute otitis media. The number of such cases is quite large. Statistically, for every minute saved in brief consultation, one minute extra is available for the more difficult problem. Which is why, in spite of an average time of around six minutes per consultation, many of us have little difficulty in organising half hour long consultations when they are needed.

There is another aspect of consultation time we ought to look at—albeit, this afternoon a brief look. According to the study carried out by Professor Butterfield and his colleagues in Southwark, more than three-quarters of the population studied had at least one symptom in the two weeks prior to being questioned: most of them had more than one symptom. Only a third of the complaints had been taken to a medical agency (to use Butterfield's phrase) and this consultation had not necessarily been in the previous fortnight. The remaining two-thirds of the patients did not go to a doctor,

but that does not mean that they did not take treatment. For every patient taking treatment medically prescribed there were nearly two taking remedies chosen by themselves or recommended by a friend. Non-medical advice is sought from articles in magazines and books; it is culled from neighbours and relatives; and it is sought from the neighbourhood chemist, today's equivalent of the apothecary, for he too cannot charge for his advice, only for his medicines.

Is such a practice to be condemned? Should everyone who feels something is amiss be advised to consult his doctor? I do not want to fall into the obvious statistical trap, so I will not say that if the 68 per cent who did not consult a doctor did so the consultation rate of general practitioners would go up by two-thirds. Most of our consultations are repeat visits or follow-ups; only about one in three are new episodes. Suffice it to say that if the two-thirds who did not take medical advice were encouraged to do so, our workload would increase—significantly.

So what can we do? 'Discipline our patients'—that is the usual advice offered. Discipline—a whole thesis could be written around the association between discipline and workload, but I am a doctor, a teacher, not a disciplinarian. So I will look at the problem from the teacher's angle. Before the process of education can begin we want to know what our pupils need to learn. What are the difficulties they are experiencing which cause us to be worried about our workload? I think there are eight main points which ought to be considered, 1. Consultations over the telephone; 2. Unnecessary surgery consultations; 3. Unnecessary house calls; 4. Late requests for a house call; 5. Evening calls; 6. Night calls; 7. Repeat prescriptions; 8. Consultations for a certificate.

I have found a principal guiding rule to cover all aspects of the art of teaching our patients to use the Health Service properly. People learn more by example than they do from a lecture. It is only of limited value to say to a patient, or for that matter to a child or any pupil; 'Do not do this again.' If an action wrongly carried out nevertheless produces the right response, it is likely that the pupil will repeat his error. But, if the action fails to produce the expected response, our pupils will learn to adjust their ways. For example, there is the late visit which turns out to be a need for a sick-absence certificate which 'the firm must

have by the morning'. We could issue the certificate there and then, and ask the patient not to call late again if they only want a certificate. But how much more effective is the lesson if the certificate is not issued. 'I am sorry, I do not carry certificates in the bag I use for emergency calls! You or a relative must call—by appointment—at the surgery tomorrow and collect one.'

Let us consider these eight points. Firstly, consultations over the telephone. When the consultation at the doctor's office has to be paid for, and when the house call costs even more, a consultation over the phone is a not unreasonable economy which the patient will want to make. But what can be done over the phone? Certainly the patient cannot be examined. Nor can his psyche be properly assessed. Furthermore, the phone interrupts the work we are doing, and that is usually seeing another patient. Why should the patient who is with me in my consulting room have his consultation interrupted by the patient on the phone?

I know how frustrated I feel when the phone rings at a crucial point in the consultation. How much more frustrated must the patient feel? Oddly enough, it is usually the patient who objects most to his own consultation being interrupted, who wants to speak to me on the phone.

Then the unnecessary consultations in the surgery. I have already referred to Professor Butterfield's study in Southwark from which it would seem that two out of every three patients passing our surgery door would have a reason to enter. If they chose to do so chaos would ensue. Furthermore, I believe—and Freud made reference to this point—that the patient must have some respect for the consultation. The consultation must have some status to be of value. The cost does not have to be measured in terms of pounds, shillings and pence, but the casual consultation 'while I am here, doctor' probably benefits the patient little and annoys the doctor a great deal.

It is my practice to resist the casual consultation. I see all patients by appointment, but my receptionists are instructed never to refuse a patient an appointment at a particular session if it is at all possible for the patient to be seen. In other words, the casual patient who wishes to see me is asked to return when there is a vacant consultation time in perhaps half hour or an hour. Naturally there are exceptions to every rule; if I have a gap then the receptionist will ask the patient to see me straightaway. I am particularly firm with the patients who ask me to

see one of their children they have brought to a consultation set aside for themselves. I try to make it clear to them that a time has been allocated to cope with their problems. That if they wish me to deal with the problems of the child I would be delighted to set aside a time to do that, but that I cannot do two jobs simultaneously.

I am aware of the argument that sometimes it is only at such double consultations that the vital problem is revealed. My own experience of that situation is that it is more anecdotal than factual.

We remember the one time that such an event did happen and forget the hundreds of times the extra consultation was irrelevant and often unnecessary. Furthermore, because it had no status it had no meaning either to the patient or to myself. If I wait for the receptionist to get the extra patient's notes I am delayed even more. Frustration is added to frustration. We must accept that there is a world of difference between organising one's consulting sessions and placing a barrier between ourselves and our patients. I am strongly opposed to restricting the right of patients to consult as often as they think necessary. I am equally in favour of making the patient do some of the work at the consultation, for the attitude of the patient is as therapeutic as most of the medicines we offer.

So we go on to unnecessary house calls. There are various types. Firstly, we tend to take it for granted that a feverish child ought to be visited and not brought to the surgery. Experience has shown that—to quote a professor of paediatrics in a recent TV programme—'illness in children travels safely.' This is particularly true of babies in arms. We also tend to revisit too often. Not so long ago I did at least one follow-up visit for practically every patient seen at home. I now invite patients seen at home to visit me for follow-up (by appointment) at the surgery, indicating the sort of time I expect the illness to take. But I always add 'If you are worried or things are not going according to plan, let me know and I will come and see you'.

It used to be accepted that elderly patients were to be visited regularly. Stephen Taylor, in his book *Good General Practice* spoke highly of this as an indication of the quality of the doctor. But is it any longer a criterion of good general practice? If these patients need to be visited frequently, is their need medical or social? If their need is social, would not the visit better be done by someone trained in social work? And if their

need is medical should not the visit be conducted on a medical basis? But how often are these patients examined at a routine visit?

We all know the story of the GP who emphasised his need for routine visits to his chronically ill patients:—'Yesterday I visited Mrs Smith. I found she had fallen down the stairs just five minutes before I arrived. Had I not got there at that time and got her into hospital, she would probably have died.' But what were the statistical chances of his arriving at that critical moment? It is just as likely that he would have arrived five minutes before she fell and far more likely that he would have arrived a day, a week or a month before or after the accident.

I have already described how I cope with emergency calls which are not emergencies. Similarly, some patients request a house call when they could—and should—have visited the surgery. The patient sometimes thinks it would be easier for the doctor 'to pop in' on his rounds. Oddly enough, they usually say this when they think the matter is unimportant. 'It's only for a prescription'. My receptionists have long been used to receiving requests around midday for an appointment to see Dr Carne in the surgery that evening from a patient who has already had a visit. I find that I rarely get a request from those patients for unnecessary visits a second time. But they stay on my list!

So we go to the question of late requests for visits. In the pre-antibiotic era when all the doctor could do for the feverish patient was to offer sympathy and his attention—even to the extent of staying all night with the feverish child or adult who had pneumonia—it was the accepted pattern for the GP to do a night round after his evening surgery. Therefore it did not seem unreasonable that an extra visit should be requested 'during the night round'. But though night rounds are a thing of the past, it does not stop the late requests for visits. These are often for seriously ill patients and ought not to be refused. Equally they could, in most instances, in my experience, have been requested at the normal hour of the day before 10 or 10.30 in the morning. I have not yet discovered a reasonable way of dealing with this problem.

Then evening visits. There are a group of patients who do not call the doctor until they get home from work. Even worse are the families who do not call the doctor for the sick child until mother and/or father get home from work. Such a practice ought to

be resisted, but, like the problem of the late call, it is difficult to cope with. I ask my receptionists to make sure that the sick child or adult is really unable to come to the surgery. For example, the child with tummy ache who might have an acute appendix will have to travel to the hospital if I also suspect that diagnosis. They might just as well, therefore, stop at my surgery en route. Quite a proportion of requests for evening house calls may be converted to surgery consultations.

So to night visits. I remain convinced that night visits follow an attitude of mind of the doctor rather than reflect the degree of illness in his patients. There are doctors who 'need to be wanted by their patients'. These doctors encourage night visits by emphasising the severity of minor illnesses. Every acute otitis media given penicillin is 'a child saved from a mastoid' and the mother is told this is in no uncertain language. Every upper respiratory infection is a potential pneumonia—'It is lucky you called when you did.' Is it not obvious why such a doctor has a lot of night calls? As Max Clyne has said, many night calls are cries for help rather than a medical crisis. If the patient knows that their doctor is willing to help them during the day, the urgency often seems to disappear during the night.

About ten years ago the late and much lamented Ian Grant, who was both Chairman of the BMA and President of the College of General Practitioners, taught me a most useful lesson. At that time I was rather proud of the many medicines I carried in my bag. You will remember that in those days it was fashionable to carry a miniature trunk with every conceivable instrument and potion. He looked at the contents of my bag and said that when the patients call at night it is not Dr Carne they are calling but the supplier of sleeping pills and indigestion tablets. He advised me to remove all non-essential medicines from my bag. Now when I make a night visit—which I never refuse—I examine the patient and, if I think that medicine is necessary, I prescribe it on a standard prescription form for one of the relatives to get from an all-night chemist. As I say to the family: 'I am the doctor; the chemists' trade union would not wish me to infringe upon their professional rights.'

It is worth adding that the number of night call fees actually claimed by doctors in the London area, when night call fees were first allowed, was equivalent to approximately six per GP per year. Perhaps some-

one, somewhere, ought to do a proper investigation of the statistics of night visiting.

Then repeat prescriptions. In most practices there seems to be a custom whereby patients phone or write in for a repeat prescription. 'May I please have some more of the red pills and white mixture and also a cough linctus for the baby?' This should, I am told, save the GPs time. Does it? I remember that when I was an assistant in a practice where this was done the following pattern seemed to ensue. The receptionist would tell me that there was a phone request: 'May I have some more of the cough mixture I had last time?' Then, after a few days: 'May I have a stronger cough mixture?' Then, a couple of days later: 'Those two bottles of cough mixture did not help me, so can I have a letter for the hospital?' When I analysed what had happened I realised that the patients were not being unreasonable. They had had two bottles of Dr Carne's medicine which did not work, therefore they now wanted the opinion of another doctor. That I prescribed this medicine without taking a proper history, let alone examining the patient, was not relevant to the patient's complaint. He had had enough of me; and, looking back on the situation, I agree with him! Today I do not accept a phone or written request for a repeat prescription. It does not seem to add to my workload and it is another factor in emphasising the status of the consultation.

I could elaborate at length on this feature of general practice which I think ought to be condemned, but I agree that at present I am one of a small minority who think that way. The strongest answer I have to my critics is that the consultation rate in my practice is less than four per patient per year in spite of my refusal to offer repeat prescriptions without seeing the patient. On the other hand, when it seems reasonable I will give the patient enough digoxin or trinitrin or insulin or whatever is necessary to last for three months at one time. I will then arrange for the patient to make an appointment to see me at the end of the three months. Whether I issue the whole of the three months supply on one prescription or on two or more post-dated prescriptions will depend on the quantity of drugs needed.

So we go to the last point, certificates. This afternoon I only want to refer briefly to the unnecessary short-term certificates we issue. When, after discussion with the

Principal Schools Medical Officer, we discontinued the issuing of schools certificates, we did not find that our treatment of children suffered as a consequence. Indeed, it has improved because we no longer see children with a vague story designed to enable them to get a certificate for school.

I am sure that many of the short-term certificates we issue are, in effect, *ipse dixit*. Not only are they a waste of our time—and of the time of the patient in attending the surgery—but they can lead to other problems. Sometimes the patient will attempt to elaborate the story to impress me of his need for a certificate. In elaborating the story he fails to realise that he has implied that he might have a serious disease. The irregular bowel action, the mixture of diarrhoea and constipation, seemed a good reason for a few days off work. The patient did not realise that it also seemed a good reason for a barium enema and sigmoidoscopy to exclude a carcinoma of the colon. Had the patient not needed a certificate, he would not have needed to invent that story. He would have saved himself a lot of discomfort, and the National Health Service the expense of the investigation.

One of the difficulties that faces us when we come to consider the problems of workload is that we know so little about it. Most of those who criticise the published evidence of workload know least about their own workload. Following the publication of *Present State and Future Needs of General Practice*, I met many colleagues who were critical, if not abusive about the suggestion that they work only forty hours a week. But when they started to calculate their own hours of work they found themselves hard put to get anywhere near forty per week.

I am sure that many GPs feel frustrated. We encourage our anxious patients to talk to us about their problems. Is it not time that we encouraged GPs to talk about their problems? And is it not time that the profession and the administrators started to listen to what was actually being said? Then, perhaps, workload would fall into its correct perspective.

Discussion

DR E. GANCZ: I feel like an echo chamber, agreeing with all that Dr Carne has said. There are some very small points, which I wish to raise. Some of you may have heard me speaking at one of the general meetings of the College and saying that education on

normalities should start at a very early age. A child of five, for instance, is expected to learn one of the most abstract and difficult things in life—to read and write—but it is assumed that they cannot learn simple anatomy, which I think is completely absurd. If this sort of thing was taught at school at an early age, I am sure that our consultations would fall very much because now we have to explain normal things to patients.

DR P. HOPKINS: How does Dr Carne fit in teaching patients not to come for unnecessary consultations with encouraging patients to come on the earliest manifestations of what may be malignant disease? We were told this morning that we should seek out people for screening in order to diagnose their illnesses before they actually get symptoms. On the other hand, Stuart Carne is telling us that we should teach patients not to consult us unnecessarily. If they have early symptoms of carcinoma of the colon, this early teaching might teach them not to come until it is beyond treatment.

DR STUART CARNE: The expression I used was that we must accept that there is a world of difference between organising one's consulting session and placing a barrier between ourselves and the patients. I am strongly opposed to restricting the right of the patient to consult as often as he thinks necessary. I am equally in favour of making the patient do some of the work at the consultation, for the attitude of the patient is as therapeutic as most of the drugs we offer.

DR S. PASMORE: If the doctor could remove 24 patients from his list of 2500, he would have no problem of workload because it is those 24 patients who cause all the trouble. I am talking about a certain type of neurotic, the person who is immature and for whom no amount of psychotherapy makes the slightest difference. This is the group which drains one, and one's secretary and one's wife.

DR J. WOODALL: I congratulate Dr Stuart Carne on his material and his delivery. One aspect we have not thought about enough is that two thirds of the consultations are return attendances. Very little seems to have been done on working out the best time to ask them to come back. In most cases do we invite patients to come in 10 days or after a week's interval? This kind of operational research would be worth while

and could make a big impact on the amount of follow-up we do by finding which of it is useful.

DR J. WILLIAMSON: I should like to support Dr Carne's statement that the routine visiting of elderly patients is something the general practitioner should look at coldly and objectively. By all means, if he has time and his workload is not excessive, he should visit. However, it is better to examine

them from top to toe than to go social visiting to the home once a year.

I was in general practice for a long time and I have an arrangement I can recommend. In the practice where I worked there was a passage in which there was a hierarchical pot. The twenty-four families which have been mentioned always induced me to take a flying kick at that stand. It was a great relief to me!

Equipping the General Practitioner to Handle Social Problems

Professor Margot Jefferys

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I think some of the things I say will be rather repetitive of points already discussed but I will say them as otherwise the logic of my argument might be destroyed.

The first thing is to talk about the meaning of the term 'social problem' because one of the main obstacles to equipping the GP to 'handle' social problems is the confusion which surrounds the term. It is used in many different ways, and we shall not get very far if we do not make clear from the start what we mean by it and the nature of the GP's possible concern with it. A taxonomy of social problems may be a useful device for helping us to think about the question raised by the title of my talk.

Social problems can be considered either as attributes of individuals, or as conditions whose existence in a social system undermines or threatens to undermine the wellbeing, or sense of wellbeing, of that social system as interpreted by its spokesmen. For example, there is a general consensus of opinion, that, if there are many individuals living in relative poverty, in poor or over-crowded housing, in broken homes or in social isolation, or if there are many individuals labelled delinquent or victims of alcoholism or drug addiction, a social problem exists; that is, the wellbeing of a society as a whole, non-sufferers as well as sufferers, is undermined by the existence of the specific phenomenon, and action is indicated.

The general practitioner, like any other individual in a social system, is more or less threatened by the existence of such problems — or by departures from the socially-determined implicit norms and values of his society, and he may become involved in community action to seek to reduce the condition.

In some instances, however, the social problems may be defined by the society primarily as health problems, as for example in the case of drug addiction or venereal disease. In these cases the medical practitioner, or medically based team, in or outside hospital, specialist or generalist, may be seen as best suited to tackle it on behalf of society. In other instances, however, society may not see the medical practitioner as the person most capable of tackling the problem, although there may be increasing recognition of a health component in the specific social problem (as, for example, in the case of broken homes). Nevertheless, since it is legitimate for those who are defined or define themselves as ill to seek medical advice or access to service for which

the general practitioner acts as gatekeeper, the latter is often involved, whether he likes it or not with individuals who, directly or indirectly, are victims or perpetrators of social problems.

In these instances, high quality medical care demands that the general practitioner should know to what extent and in what way the individual's social circumstances or behaviour has contributed to the onset and course of his illness and, obversely, how far his physical and mental infirmities contribute to his social difficulties. Additionally, he needs to know how far social circumstances and behaviour may have to be modified in order to ensure the most favourable possible outcome of the individual's illness episode. In short, ideally, he should be as equipped as current knowledge enables him to be to understand the interaction between both the presenting and the background medical and social problems.

Up to now I have been talking about social problems in the sense of social attributes which are generally considered undesirable, both for the individuals who possess them and for others in the same social systems, whether these latter are small social systems like the family, or larger social systems such as work units, schools, clubs, neighbourhoods, towns or nations.

But let me state dogmatically, because I do not want to argue this point today, that everyone is the product of his past social environment as well of his heredity. His current health, as well as what action he takes or does not take about it, are subject to social influences past and present. As far as health is concerned these influences can be benign, neutral or pathogenic. Moreover, their effect on health and health behaviour can vary with time and circumstance.

For example, a man's inflexible adherence to the role of sole economic supporter of his household may have been valuable from the point of view of his own health and social wellbeing for much of his life, but may cease to be if it is maintained after he has been involved in an accident which leaves him seriously disabled.

Consequently, it is not enough for the medical practitioner to know something about the etiology of gross social problems. In the same way as he needs to know something about the diversity of physical normality as well as of gross pathology, he also needs to know about the range of social norms that he is likely to find among

his patients and their relationship to physical and mental health.

Ideally, then, a general practitioner wanting to advise or treat any patient should be aware of the way in which a man's way of life and his position in the social systems, large or small, of which he is a part have contributed to his illness and to his seeking help and are likely to affect the treatment and management of the disease and its prognosis. The general practitioner needs to know this not because he has a direct remit to concern himself with the social wellbeing of individuals or of the community, as other professional workers may have, but because there is a social component of some sort in every illness and in every consultation.

In this sense, equipping the GP to handle social problems means, first of all, giving the medical practitioner as much knowledge as possible about the socially determined components of illness and of the ways in which individuals who are defined as ill behave.

The next questions which must be asked are, then, what knowledge does exist about the social component of disease processes and illness behaviour and how can it be transmitted and utilised by the general practitioner? The answer to the first of these questions is that there is an extensive and rapidly expanding body of knowledge to which both epidemiologists and behavioural scientists have contributed about social factors as etiological agents and as determinants of the course of the disease in individuals. It is true that experience and insight are still important (and always will be), but it is no longer necessary for the GP to rely exclusively on his own experience and intuitive judgment to make an assessment of the part which the individual's social circumstances and relationships are likely to play in the onset of a man's illness or in his attitude to it.

The medical practitioner can increasingly call on the results of epidemiological studies of social factors in disease, and in doing so he is likely to make a sounder and a more appropriate programme for therapeutic intervention. Moreover, he can also draw on the findings of psychological and social studies of such phenomena as doctor-patient and family relationships to gain a greater knowledge of the likely response of individuals in different social classes or cultural sub-groups to the impact of severe illness or chronic incapacity.

How is the GP to acquire this knowledge? The Royal Commission on Medical Education suggested that all medical practitioners should be introduced, at an early stage of their training, to the methods and concepts of human biology. They interpreted this as embracing a man's social being as well as physical make-up.

If this recommendation were to be carried out—and we have to recognise that it may be difficult to do so in all medical schools, in the short run given the shortage of behavioural scientists and the conservatism and inertia of the establishment of some medical schools—then all doctors, not only GPs, should be better able to make finer judgment by taking the social aspects of disease into account.

But in my view the recommendations of the Royal Commission for post-qualification training of GPs do not go far enough if the intention is to train them to become specialists in this field of knowledge. For, if the term 'specialist' is to have any real meaning when applied to GPs, and not merely be a sop to them in a medical world which accords high status to the specialist, it should mean that they are experts in handling the psycho-social factors in the disease and in the patient's response to it.

Instead of stressing the GPs' need for further post-graduate training in a number of special fields—16 are mentioned by the Royal Commission—the intending GP should be exposed, both through academic studies and possibly by placement in social work agencies, to the new kind of expertise that exists in the field of behavioural sciences as applied to illness. This might sound an outrageous suggestion to the medical profession, which is accorded and accords itself a much higher status than social workers, but at the very least systematic in-service training in general practice should take place in medical or psychiatric centres where there are social worker complements.

My first general conclusion is then that radical changes need to take place in the GPs general and specialist medical training if he is to be better able to understand the psycho-social aspects of the problems with which his patients present him.

At the same time, the treatment of illness or disability, especially in the chronic form which it is increasingly taking, whether episodic, static or progressive, cannot be left to the general practitioner. Many other workers employed by local authorities, central government departments and voluntary agencies are involved with families where

chronic illness or substantial handicap is present. Equipping the general practitioner to handle social problems in this sense means creating the kind of work setting in which his work complements that of others with relevant expertise.

How can this best be done? If the recommendations of the Royal Commission on Medical Education and the Seebohm Committee are to be implemented, general practitioners in the future will work from centres consisting of about a dozen doctors with ancillary nursing, midwifery and health visiting staff. Social workers employed by a social service department may be attached, on a full- or part-time basis, to such centres. Alternatively, GPs or other members of the health centres may refer their patients to the social service department and some worker within that department.

It is difficult to forecast how satisfactory the alternative types of organisational structure are likely to be from the point of view of achieving the team work which I have implicitly assumed is desirable if the social aspects of illness are to be seen as an integral part of the total treatment situation. I feel that if social workers do not become fully integrated members of the health team, their usefulness, both in providing a service directly to the patient and in contributing to the process of mutual education which should take place between doctor and social worker, will be limited, certainly as compared with the situation in which the latter are regarded by both general practitioner and patient as members of the same team.

This can be inferred from the reports which have recently been published by Goldberg and others in the *Lancet* and, earlier this year, by Forman and Fairbairn, on the work of social workers in general practice settings. The results obtained by Anderson, Draper and their team at Guys also suggest that the doctors' appreciation of the part which a health visitor can play in helping to handle the socio-medical problems of the elderly or the multi-problem family is greatly increased when the health visitor works with them rather than from a local authority base. There are these and other indications that the closely integrated team is more effective than the situation where one person refers to someone working in another agency.

It seems to me that there is here a challenge for health visitors. It is possible that if the health team develops into a close knit doctor - health visitor - district nurse team

without a social worker, the health visitor may increasingly take over the role which the Seebohm Committee suggests should be that of the social worker attached to the social service department. This is something which social workers may not view altogether with distress since, at least into the next decade, the shortage of health visitors and social workers is likely to be even greater than the shortage of general practitioners.

The Seebohm Committee did not examine, critically, the health visitor's current training programme, workload, methods or work setting, and it may be that general practitioners will find it easier and more fruitful to utilise her services than to refer patients to a social service department.

Finally, equipping the GP to handle social problems within a domiciliary team involves training him to work with other professional workers. Usually his only experience of multi-disciplinary team work has been gained in hospital and he may carry over inappropriate lessons from it to the domiciliary field.

The Royal Commission on Medical Education and other investigating bodies have suggested that the GP should be the leader of the health team and should be consciously trained for such a leadership position. I believe this emphasis is wrong. The need is rather for the GP to learn to become a team member. He may well emerge as the leader, necessarily so in emergencies involving risk to life or limb. But in much of the work with the elderly, the handicapped, the neurotic and the feckless, the social aspects of the socio-medical problem may be the most significant, and in these instances it may be more appropriate for the social worker to lead, or take decisions, if it is impossible to reach agreement. One of the problems which doctors must face in the next two or three decades is that of better recognizing the status needs of the other professions which contribute to health and wellbeing and of not blocking the needs of these professions for social prestige and recognition of their competences.

To summarise, then, I have argued that to equip the GP to handle social problems means, first, giving him a much sounder and deeper knowledge of the social aspects of disease: second providing a setting in which he can work with others—particularly social workers—who are equally concerned and have an expertise in this field, and thirdly, training him to work with others in a multi-disciplinary team in such a way that

all the members of the team can make their fullest contribution to their joint endeavours.

Discussion

THE CHAIRMAN: Perhaps what we ought to concentrate on is Professor Jefferys' last point. That is this problem of fitting into a team working with others, particularly in one in which we do not assume the leadership immediately as of right. This brings one back to what was said by Mr Teeling-Smith and Professor Alwyn Smith. When looking at the place and nature of general practice, it is this general care, working alongside the nurse and the social worker that is of importance. Where should the health visitor fit in? We have 8000 health visitors to fit in. And where should the social worker fit in?

The point about the papers, which Professor Jefferys referred to by Goldberg, Fairbairn and others, is that the workload of the social worker is very much lower than the potentiality of the health visitor. This is an important point to bear in mind when looking where to fit in these people. The social worker works at the same level as a hospital specialist to whom we refer special cases. This helps patients to resolve relationships with a team rather than with an old-fashioned—not too old-fashioned—doctor working on his own. Is there anyone with practical experience of working with a social worker in the same practice?

DR M. J. F. COURTENAY: I agree there are tremendous problems here. Certainly the workload of my psychiatric social worker is less than mine. The health visitor's, as you say, is much greater. The problems of working together I have found much less in practice than I expected and the real problems are those which I did not anticipate. To my mind, the crux of the matter is, what am I shrugging off which I should not, and what are our real roles?

THE CHAIRMAN: This is a very good point because we have worked with a health visitor and mental welfare officer in our practice. We have had these problems which Dr Courtenay referred to in working out the role of the doctor, and particularly the visitor who had had some psychiatric training and the mental welfare officer who

has had training in community care. It produces problems of re-orienting a mental welfare officer to the new field of practice. Often it has created more problems, particularly in marital relationships and other things, than existed before. They are the sort of problems with families who before were living in equilibrium and have actually taken steps to get divorces which before did not arise. Is this a good thing or not? This is a problem.

DR R. L. MEYRICK: I would hate to practice without them. There is no doubt that our health visitor has found her role and we know what to expect of her, but for all that no one would believe that she does not make work for us, because the workload has increased. She works in her own professional right and refers problems to us which before would never have come to us.

On the other hand, I have only a limited experience with the social worker, and that only in the field of the elderly people particularly those who are housebound. Here the load has very considerably diminished by having a social worker available to assess the social needs of the home. I believe that the problems of these elderly people have decreased as a result of the social worker being available.

In respect of children and mothers with illegitimate children, the psychiatric worker and childrens' officer come back into that large problematical group and create a lot of work. I am not sure whether they make more work as a result of their activities than might be there if I could do the work myself.

DR M. FISHER: I stress the word 'rehabilitation' and ask whether the general practitioner is in fact aware of the agencies at his disposal for the rehabilitation of his patient. I was extremely interested and happy to note that Professor Jefferys said the GP might well become part of the team. This is what we have at present in many of our physical medicine departments. The patient is sent up to us and the GP is immediately made part of that team so that when the conference takes place we have the patient, the general practitioner, the social worker, the physio and occupational therapist, the psychiatrist and the DRO. This team meets; we discuss the patient and we discuss what we can do. I think the time has arrived when the GP must become part of that team if he is to succeed in carrying out his work as a doctor and the patient is to

receive proper attention. It is of the greatest importance that the GP be made aware of the help he can receive at these departments of physical medicine and rehabilitation.

DR P. HOPKINS: Surely what Dr Fisher has said is the ideal for medical practice in every case. The awful business of the two types of doctor, one of whom refers to the other to get a hospital bed, has developed into a state where a conference goes on about communications. This shows that there is a need for communications and Dr Fisher has told us the ideal way that this can be done.

We should meet with all the agencies concerned whether it is on rehabilitation or a surgical consultation. This is ideal, but there is a shortage of doctors. We are told that there is a shortage of health visitors. This underlines the need for working together, the GPs and the ancillary workers. I have had attached to my practice for some time a social worker and a health visitor and this has made an enormous difference to the way in which I can work with people. Recently I have also had a district nurse attached.

I remember coming back from a visit to the Soviet Union full of envy. When the doctor there went visiting he always had a district nurse with him. I think it is very useful to have a nurse with you when you visit a patient. It is a very good thing for the patient and for the doctor—and for the nurse for that matter.

It is not always easy to have a health visitor attached to a practice. I have found that there is a duplication with social workers doing the same sort of things as we are unless they are actually attached to us. This leads to a waste of everyone's time; it

is much better if attachments can be made. This is something we should press for—attachment of social workers and health visitors. It would save time by reducing duplication of services otherwise provided by different agencies for the same patient.

MISS G. PADFIELD: I have worked in general practice and I was the first health visitor to work in a general practice teaching unit with a medical social worker. My experience there, working as a health visitor, with the medical social worker and with the GP—and I acted as an all-purpose nurse in this practice—was that our roles came to us naturally. There was no difficulty at all. The starting point for most work was in the surgery, either for a call or a visit. If it was a medical need the GP visited; if it was a nursing need, I went; if it was purely a social need, the almoner went. We all had a place in the various cases. This was as easy as falling off a log and there was no problem at all about whose role was which.

Inevitably the health visitor's case load must be bigger than that of the social worker because being a skilled social worker involves intensive case work and the visitor has neither the time nor the ability to do this. I appreciated what was said about the relationship where the health visitor invites her social worker colleague to deal with a situation she is unable to deal with herself. This was not accepted by all health visitors because, like the GPs, over the years to do our job of promotion of health we had to undertake certain social work. Our training did not help us to do this in the skilled way social workers did. The Royal College of Nursing set up a liaison committee of social workers and health visitors. The result was that we saw ourselves as pieces of a jigsaw puzzle, all having a part to play in meeting the need of the community.

I FIND the task of reviewing today's proceedings a terribly difficult one because we have certainly covered a lot of ground. You will have to excuse me if I restrict what I am going to say to what we should have been talking about—which is human relations in general practice.

I am going to get out of the difficulty by starting with a look at the educational problems of medical care and general practice in particular and those aspects only which relate to personal relationships—which means that I shall leave out a lot of the very interesting discussions we have engaged in. Also, I have taken this invitation as a thinly disguised invitation to discuss yet another view of medical care, although I find my view of the situation of medical care is really that of most of the people in this room.

I start by taking Dr S. Pasmore's view of medical care. The main aim of any system of medical care is to help the patient as an individual, or community of individuals, to solve or ameliorate their clinical problems. This is the 'general systems' approach. These problems have physical, emotional, and socio-economic components and the patient may not even be aware that he has a problem. The aim of all medical care must be to bring the maximum benefit to the patient within limitations set by restricted resources. This is largely what Dr Carne told us in his very lucid account of how to organise general practice.

I believe that this is the only absolute value in medical care and all the other so-called 'values' and 'principles' are generalisations appropriate to some more limited problem, whether clinical, social, economic, organisational, or ethical. The priorities must be determined by the relative effort expended on the assessment of the problem as compared with the action taken to deal with it. We must also look at prevention compared with cure, of the treatment of symptomatic illness compared with its pre-symptomatic phases, the potential benefits to one patient compared with all other patients, and finally, the deployment of resources from a centralised hospital must be compared with those from the local domiciliary services.

Apart from the simple economic balance sheet based on money, other resources, and human personnel, there are ethical considerations. For example for any given expenditure of medical effort prevention must always be preferred to cure and pre-symptomatic to symptomatic diagnosis

when presymptomatic diagnosis has some advantage for the patient. In this assessment procedures have priority as the primary component of any medical care system over therapeutic procedures. You cannot have adequate therapy unless the assessment procedures which have come first are as adequate as they can be.

The range and quality of clinical problems brought to medical care are directly related to the patient's own assessment, as Professor Alwyn Smith pointed out, but they are also related to the presence of effective treatment. One by-product of the increasing control of an organic disease or serious mental illness is the up-grading of that illness to the status of an acceptable, because soluble, clinical problem.

Various speakers have suggested the need for a change of title of the general practitioner. The general practitioner has inherited a mantle from the past. His major role has switched from that of general therapist to that of general or primary assessor. It was evident from many contributions that our medical care system depends, and has depended for many years, on the efficiency of primary assessment by the general practitioner and our medical care system is efficient because the GP is not only the primary assessor but also the primary therapist, and also because the conjunction of these two functions of primary assessor and therapist is in turn dependent on and also ensures maximum clinical continuity between any doctor and his individual patient. Doctors like to have a continuing relationship with many of their patients, and this applies also to most patients in relation to their doctors. It is only from this continuous interaction that the basis for efficient general practice can be maintained.

In this context there are only two acceptable systems of medical care. The first is the one we have been talking about, based on a basic group of primary assessors who must be equally at home with the assessment of emotional and organic disease. This basic group can be backed up by any number of specialists hierarchically disposed behind them. This assumes as a corollary, a tightly knit kind of domiciliary care team of workers to support the primary assessment process. This must inevitably, for economic and other operational reasons, be in a domiciliary setting. This is the sort of rationale I would see behind future good general practice.

There are good operational reasons why we have this pattern. The dynamics of a

successful example of this medical care system are based on two factors. Firstly, a system dependent on the establishment of human relationships demands time for its development and secondly a certain minimal population stability is essential. Present cultural trends are against this. Many speakers made much of these problems and the importance of these points. This may be one facet of a much larger cultural problem. It may be that cultural stability will demand some scaling down of this social mobility and the problems which it presents to medical care are only one part of this neglected aspect of our social organisation.

Dr Williamson went very explicitly into this aspect when he was talking about the neglected and isolated old people.

The second factor concerns the general awareness in the culture of the advantages of close personal relationships at all levels. In the absence, for example, of a minimum number of sufficiently physically stable patients and doctors, not only will the personal relationships not be built up, but also the awareness of all those secondary advantages of close personal relationships will be lost and drop out of the repertoire of the assessment system. I believe that this is evident now in the centres of our great cities, as well as in large areas of the USA and Sweden.

The second alternative system concerns the evolution of automated primary assessment. The resultant data is then used within the context of the transient personal relationship which can be built up during the short-term contact between the patient and the appropriate specialist. This is the rainbow with the crock of gold at the end a recurrent crock of gold which I think will turn out to be like most such, wishful thinking.

The third choice is in effect a variant of our first. This is the system where the primary assessor is not medically qualified. Provided that this assessor can consistently recognise the distinction between emotional and physical elements of disease, and also when the assessment or therapeutic aspects are of such severity that referral to someone medically qualified is mandatory, this system may work—and it does work. I stress that the first problem here is ability to distinguish emotional from physical components because I believe that it is in this field—this is the point Dr Chamberlain made—that we can be most powerfully preventive. It is the positive results of the preventive approach that general practitioners all know about compared with the

still nebulous returns from machine-based data.

Finally, a few words about the dynamics and structuring of personal relationships. Not a great deal was said about this until Professor Jeffreys presented her paper. This stems from the fact that you cannot be scientific about data which is generated from personal relationships; the nearer you get to your own ego, the more difficult it is to be objective and scientific. There is the relationship between the patient and the doctor, between members of the domiciliary team, and finally personal relationships between the domiciliary team and hospital-based doctors—which we have not touched on, except for Dr Hopkin's comments about communications.

I believe that some sort of structuring of personal relationships in medicine is essential and parallels the more general personal relationships which provide the basis for any satisfying and whole human existence. Man must live in groups and individual man achieves his full individuality and humanity only in the context of social, emotional and physical interactions with his peers.

What are the motivational elements which underline the actual patterns of human behaviour associated with personal relationships? All normal human individuals have a need not only physically to associate with their fellows, but also to present to their fellows from their own personal views and behaviour just those views or activities which the individual believes his fellows would like him to have or to present. This is, of course, the basis of all the normalisation processes which underly human group dynamics, and which ensures that a group will not only operate as a unit, but can and will adapt its activities to changing circumstances.

It is also the basis of that universal human trait, hypocrisy. It is true that this normalisation process is channelled through the dominant member of any dynamic group, for the other attribute of group man is that he prefers to associate with his fellows in non-sexual dynamic groups of, ideally six to 30 members with a rigid status hierarchy. This tendency to form a rigid status hierarchy in conjunction with the universal need of all men for continuity in time of such relationships and the role taking and rule following propensity of man lie at the basis of all cultural structuring and therefore of stable civilised society.

There are, of course, many other kinds of basic group patterns but this is the basic one in society. The other basic group is the nuclear or expanding family unit. What are the implications of this for medical care? In the doctor-patient relationship which has evolved for a special purpose, the doctor, willy-nilly, tends to be placed in the position of authority. The theoretical exception is the relationship of a client to a Freudian analyst. A rigid authoritarian assessor whose views are implicitly evident, will tend to get back from his patients a reflection of those views rather than the real view of the patient of his complaint. The real view may come across only to an assessor with a more open and permissive personality. This point has often been made by implication. Dr J. Pasmore dealt with this explicitly. Wolff, in a study of Canadian general practitioners (1), has some practical things to say about this, in an unpublished thesis. The scientific basis—such as it was—for assessing the attitudes and values of doctors, was taken from work done in advertising.

However, the process may act in reverse in the therapeutic situation. It is clear, although the objective evidence is still sparse, that individuals will indulge in, or at any rate are more likely to indulge in, some pattern of behaviour which their fellows in general approve rather than some other, and that this tendency is also evident in the situation where the individual has a personal relation with some authoritarian or father figure. In other words, there must be times when the doctor has to be authoritarian rather than permissive in a therapeutic situation even though he should be permissive or open in the assessment situation. I believe that this is one area where much more work should be done if we are considering how effective we are as doctors, assessors and therapists.

The structure of personal relationships among the domiciliary team, presents another set of problems. They were touched on in Professor Jefferys' paper. The dynamics of human group behaviour dictate maximum stability when status is rigid, hierarchic and clearly defined. A group in which all are equal can succeed as an effective unit, but the results depend on strong bonds or personal relationships built up over time and the stability depends on compatibility of temperaments to a degree unnecessary in the more rigid hierarchical group. It is no coincidence that military, religious and Civil Service establishments

all favour hierarchical systems where the structure is more permanent than the individuals who move in and out of the roles of which it is constituted. Hospital medicine is based on three interacting, but quite distinct and rigid, hierarchies, medical, nursing and administrative. I do not think that we can ignore the lessons implied in this.

While a hierarchically structured group remains stable with up to 30 members, four is probably the safe maximum size of a stable group of equals. There are groups of six who work well together, but you have to have unusual arrangements when you get above this number. This is an easily resolved problem. If group practice is carried on under one roof with 12, it is easy to have three groups, not completely isolated, of four arranging their main work.

I am old-fashioned enough to believe that there will have to be a boss if an effective team needs to be constituted where its members do not remain together for many years. I also believe that the structure of the hierarchy will have to be laid down from the outset and cannot be left to chance. Standardisation has to come in. After all, professionalism, when you boil it down, concerns the systemization of rights and duties and the establishment of rules of behaviour which, to be effective, must regulate the relationship of individuals, without friction. We have not started to think of the structuring of the ideal team in these terms of systematised roles and rules.

I also have doubts about the effectiveness of large teams as primary assessors compared with the present one-man one-patient arrangement of British general practice, for the reasons I have given. I think you can have effective teams, but they demand that much more time should be spent in dealing with any one problem. A very important point was raised on the question of the effectiveness of the doctor or health visitor in the one-man type assessment described by Dr Carne. There must be problems where economics come into the decision making process.

If we accept that the personal doctor as primary assessor has a major part to play until proved otherwise, it is evident that we have to supplement him by supplementary outgoing assessment systems based mainly on social worker members of the domiciliary team and psychiatric social workers dealing with some of the emotional problems. I also remain convinced that the personal doctor is the most effective primary assessor in the phase of ante-natal care,

certainly to the 36th week and for the mother and baby from 48 hours after the confinement. I do not believe that good obstetric care necessarily means that the GP has nothing to do with his patients once they become pregnant.

What are the implications for future discussion or future study from today's proceedings? First of all we need an operational research model for medical care. We still have no operational basis for a medical care system—at least nothing that would satisfy for instance, people in industry. They would want to know what they were doing before they got down to supplying finance and so on. This is still the first priority. Such an operational model must take into account the interactions of the people who will take part in the process, particularly in the presence of an increasingly mobile population. We must look at the mechanics of self-treatment by patients. An enormous amount of effective treatment following such self-treatment is going on now. Perhaps such studies are inhibited by professional arrogance for we cannot believe that the patient might make effective decisions.

The second phase is to conduct real trials of the different possible systems for delivering medical care in various social situations.

Thirdly, there is a need to stimulate interest in the basic qualities of interpersonal relationships and its relation to medical care. Professor Jefferys quoted perhaps all the work that has so far been carried

out in this field. There is a relationship of all this to the training of the new generation of doctors and their potential non-medically qualified partners in the domiciliary care team. One thing seems quite certain from the almost universal comment of participants in this seminar today and that is that the training of everyone in this room seems largely irrelevant to what they are doing now whether medically or socially.

There must be continuing assessment of preventive and presymptomatic procedures of all kinds. There must be continuing attempts to understand the mechanisms which make us want to go on learning. There must be exploration and assessment of the effectiveness of machine based systems for assessing clinical problems and whether they provide the patient with an emotionally satisfactory substitute for the human assessor. Increasingly one is becoming aware of descriptions of work in which studies have been conducted showing that in certain circumstances individuals can get back from machine based systems a satisfactory and satisfying emotional experience. The place in which this seems most strongly reported as satisfying is a machine based system for assessing and advising on sexual problems. This apparently has provided a service to users which they had not been able to obtain anywhere else.

I apologise for the patchiness of what I have said, and I am afraid that I have gone on at great length, but this really reflects the enormous range covered by speakers in the very interesting discussions.