PRACTICE OBSERVED

Practice Reflections

Attitudes to psychological illness in general practice

A historical cycle complete

K B THOMAS

In this introverted and subjective society, when so many aspects of life are looked at from a psychological point of view, it is not surprising that in medicine the psychological diagnosis is a common and popular one. For the doctor to seek—and of course find—psychological reasons for illness is an accepted and approved principle of modern general practice. Because this view of viewing illness represents a postwar change in attitude, some have thought that the psychosomatic approach is a new and almost unprecedented movement of medical thought.¹ This is not so: the eighteenth century doctor had a similar subjective attitude to illness.

The whole man and his environment

Eighteenth century medicine was holistic and ecological and was much concerned with the relationship between the mind and the body. Jerome Gault² professor of medicine at Leiden, writing on the harmony of mind and body said, "There is hardly any smallest part of man in which something of mind and something of body and in a measure a mixture of both, is not to be observed." In 1733 George Cheyne³ published a book entitled *English Diseases*, in which he described the nervous conditions of the English, who he thought were particularly susceptible. "These nervous disorders," he wrote, "are computed to make almost one-third of the complaints of the people of England." Sydenham⁴ in 1753 thought that no chronic disease

Waterloo, Portsmouth PO7 7AH
K B THOMAS, MD, general practitioner

occurred so frequently as hysteria and that it accounted for one-half of all his non-febrile illness. And William Cullen,⁵ professor of physic at the University of Edinburgh, wrote in 1777, "That in a certain view almost the whole of the disease of the human body might be called nervous."

Doctors at this time thought that not only did they see a lot of psychological illness but that it was increasing. Thomas Trotter⁶ noted that by 1807 nervous disorders had increased to "two-thirds of the whole with which civilised society has been afflicted." As in our own time, the prevalence of nervous illness was thought to be due to the way of life and to the stresses and strains in society. Idleness and sedentary living were particularly blamed. Sydenham⁴ wrote that few women were free from hysteria "except those who worked, and fared hardly." Trotter⁶ thought that the drinking of tea was a factor: "The consumption of the Chinese plant is enormous throughout the United Kingdom; it is a beverage well suited to the taste of an indolent and voluptuous age." Perhaps this description could be applied to our own age, and it may be that psychological diagnoses are especially common at such times. Certainly Trotter's indolent and voluptuous age was to give way to the much harsher, rigorous, and stricter climate of Victorian industrialisation, when interest in psychological illness in general practice faded away.

Hard times and a change to materialism

The nineteenth century produced changes that radically altered the attitudes of doctors to illness. The rise of scientific medicine and its success in the treatment of disease concentrated the medical mind upon somatic illness, and eventually this attitude succeeded in wiping out recollections of the attitudes traditionally attached to relationships between the mind and

1158

body.⁷ This dominant interest in physical illness continued until recently. Those of us who were studying medicine in the 1940s experienced a curriculum and attitudes that concentrated on the body, and interest in and insight into things of the mind were minimal. As late as 1954 Taylor⁸ wrote in his book *Good General Practice*: "The better the clinician the less often does he diagnose neurosis."

Back to introspection

After the second world war there was once again a change of attitude, with many doctors taking an interest in and therefore reporting more psychological illness. This change took place in many countries.⁹⁻¹¹ Commenting on a table of prevalence rates of psychological illness in the United States, Lin and Stanley¹² said that the range was so great as to make the table virtually meaningless. (The rates reported after 1950 (53-333 per thousand) were much greater than those reported before 1950 (16-740.5 per thousand), and they doubted that this could represent a postwar increase of mental illness of such order. Comparing the results of the two national morbidity studies^{13,14} in general practice shows that the reported rate of mental illness more than doubled between 1955 and 1971.

In 1950 the College of General Practitioners wrote that the generally accepted figure for psychological illness in general practice was 30%.¹⁵ Commenting on a table of prevalence rates of psychological illness in the United States, Lin and Stanley¹² said that the range was so great as to make the table virtually meaningless. (The rates reported after 1950 (53-333 per thousand) were much greater than those reported before 1950 (16-740.5 per thousand), and they doubted that this could represent a postwar increase of mental illness of such order. Comparing the results of the two national morbidity studies^{13,14} in general practice shows that the reported rate of mental illness more than doubled between 1955 and 1971.

In 1950 the College of General Practitioners wrote that the generally accepted figure for psychological illness in general practice was 30%.¹⁵ Commenting on a table of prevalence rates of psychological illness in the United States, Lin and Stanley¹² said that the range was so great as to make the table virtually meaningless. (The rates reported after 1950 (53-333 per thousand) were much greater than those reported before 1950 (16-740.5 per thousand), and they doubted that this could represent a postwar increase of mental illness of such order. Comparing the results of the two national morbidity studies^{13,14} in general practice shows that the reported rate of mental illness more than doubled between 1955 and 1971.

On Saturday, Sunday, and Monday, owing, no doubt, to the inclemency of the weather, his lordship's symptoms became aggravated; and, during the night of Monday, or early on Tuesday morning, the attacks of spasmodic breathing were so distressing, and the exhaustion, so great, as to cause the gravest alarm for the immediate consequences. Her Majesty, on Tuesday morning, participating in the anxiety felt by his Majesty's friends, desired that further advice should be obtained; and Dr Quain was requested to attend in consultation with Dr Kidd. It should be mentioned that Dr Kidd had for the last three years attended his lordship in like attacks. When this request was made to Dr Quain, he declined, with great regret, to accede to it, under the impression that Dr Kidd was a homeopathic practitioner. Being, however, assured in the most positive manner that Lord Beaconsfield had on no previous occasion been treated homoeopathically, and was not being so treated on this occasion, he sought the

BRITISH MEDICAL JOURNAL VOLUME 283 31 OCTOBER 1981

And what of the future?

In the light of the past there can be no certainty that present attitudes will continue. It may be that in a less affluent society with a stricter social code we will become less inward looking and more materialistic, and this may influence our attitude to illness. Perhaps we should stop interpreting illness in various ways and recognise that in general practice many patients present with minor illness that is diagnosed and treated differently by different doctors.¹⁶

References

1. The Royal College of General Practitioners. *The future general practitioner: Learning and teaching*. London: British Medical Association, 1972.
2. Rother J. *Mind and body in 18th century medicine*. London: Wellcome Historical Medical Library, 1965.
3. Gault J. *De regimine mentis*. Quoted in *Mind and body in 18th century medicine*. London: Wellcome Historical Medical Library, 1965.
4. Cheyne G. *The English malady; or a treatise of nervous diseases of all kinds, as spleen, vapours, humors of spirit, hypochondriacal and hysterical distempers*. London, 1733.
5. Swan J. *The entire works of Dr Thomas Sydenham*. London: Newberry, 1726.
6. Cullen W. *First lines of a practice of physic*. Dublin: James Williams, 1777.
7. Trotter T. *Views of the nervous temperance; being a practical enquiry into the increasing prevalence, prevention and treatment of these diseases*. London: Hurst, Bess and Orme, 1807.
8. Taylor L. *Good General Practice*. London: Longman, 1954.
9. Taylor L. *Good General Practice*. London: Longman, 1954.
10. Taylor L. *A study of the incidence of mental disorders in Chinese and other cultures*. *Psychiatry* 1958;18:313.
11. Plunket R, Gordon J. *Epidemiology and mental illness in health*. New York: Basic Books, 1960.
12. Lin T, Stanley C. *The scope of epidemiology in psychiatry*. Geneva: World Health Organisation, 1962.
13. General Register Office. *Studies of medical population*. Subject No 14. *Morbidity statistics from general practice*. London: HMSO, 1958.
14. Office of Population Censuses and Surveys and the Royal College of General Practitioners. *Morbidity statistics from general practice*. London: HMSO, 1974.
15. College of General Practitioners. *Br Med J* 1950;3:585.
16. Kessel N, Shepherd M. *Neurosis in hospital and general practice*. *Journal of Mental Science* 1962;108:163.
17. Whitfield M, Winter R. *Psychiatry and general practitioners*. *J R Coll Gen Pract* 1980;30:682.
18. Thomas R.B. *The consultation and the therapeutic illness*. *Br Med J* 1978;3:137.
19. Thomas R.B. *The temporarily dependent patient in general practice*. *Br Med J* 1974;3:625-6.

advice of some of the most prudent and experienced Fellows of the College of Physicians, who were decidedly of opinion that Dr Quain would not, under the circumstances, be justified in persisting in his refusal. Those who have known Dr Quain, and his strict integrity in all that relates to professional honour and feeling, during his long and distinguished career, will at once accord their approval of the course which he pursued under the difficult circumstances in which he was placed.

When Dr Quain saw Lord Beaconsfield, he found that he was suffering from bronchial asthma, associated with bronchitis, accompanied by great distress of breathing and difficulty of expectoration; that his heart, though weak, was free from valvular disease; that the urine contained some albumen, but gave no evidence of structural change in the kidneys. He found that his lordship had been treated with the usual remedies, including calomel and ammonia. On Wednesday morning we were informed that his lordship passed a better night—that his more urgent symptoms were less, and during the following afternoon his lordship passed several hours on the sofa in the drawing-room. This exertion appears to have been more than he could bear, for at night he was less well. This (Thursday) morning, the bulletin issued at ten o'clock stated that Lord Beaconsfield passed a quiet night, and that his symptoms were not worse. Those who are familiar with cases of this class, will know to how much anxiety Lord Beaconsfield's condition must give rise at his advanced age. In expressing an earnest hope that the life of this, one of the great of modern statesmen, may yet be spared, we echo the wide-spread feeling of the country at large. (*British Medical Journal*, 1881.)

Practice Research

Stringent prescribing in general practice

G N MARSH

The cost of drugs prescribed by general practitioners in England rose from £16m in 1970 to £53m in 1977.¹ During that time many patients suffered from drug side effects, iatrogenic disease, drug dependency, and drug overdose. To try to reduce costs and minimise drug-induced morbidity in my practice I have adopted an increasingly stringent attitude towards prescribing. Unfortunately, there is no instant cure for the unnecessary prescribing that has become almost epidemic in modern general practice, but I report some ideas that could help other GPs.

Method

Each partner in the group has his own list of patients whose records are marked and separately filed. Patients see their own doctor except in emergencies or when he is off duty. One of the many advantages of working in this way—the single-handed practice under the umbrella of the group—is that each doctor's individual work can be studied.² The prescribing figures provided by the regional medical officer that are normally only relevant to group practices as a whole can be analysed with reference to individual partners. Not only can intra-practice figures be examined but comparisons can be made with regional averages. The Cleveland County average is broadly similar to the average for England and Wales. Fortunately, the figures given to the practice from 1976 to 1981 have always been for either January or February which are comparable months.

Results

The table shows the average number of prescription items issued in Cleveland County in the last six years—approximately six items per person per year; my figures have been about four items per

Norton, Stockton-on-Tees, TS20 1AN

G N MARSH, MD, FRCS, general practitioner

Monthly and yearly prescribing data for practice (P) and Cleveland County (CC)

	1976		1977		1978		1979		1980		1981		1976-81	
	P	CC	P	CC	P	CC	P	CC	P	CC	P	CC	P	CC
Average No. of prescriptions per patient per month	4.05	5.93	2.19	3.60	2.97	4.88	3.92	5.88	4.00	5.90	5.75	3.66	5.90	5.05
Average No. of items per patient per month	2.00	2.93	1.97	2.85	2.41	4.08	3.06	5.04	1.16	3.13	3.74	1.25	3.02	3.40
Average No. of items per person in one month	3.76	6.09	0.362	0.478	0.13	0.13	0.13	0.297	0.321	0.321	0.320	0.366	0.319	0.31
Approximate No. of items per person in one year	4.30	5.89	3.82	5.74	3.76	6.14	3.56	6.25	3.90	6.24	4.32	4.32	3.61	4.06
Total cost of prescriptions in one month to patient	2228	422.856	2175	524.637	2733	607.203	2792	766.318	3250	906.059	3681	895.360	1081	688.739
Average cost per item	1.52	1.85	1.83	2.19	2.18	2.40	2.65	2.80	2.91	2.76	2.82	2.82	2.22	2.27
Estimated cost per person in one month	2.54	0.71	0.35	0.88	0.46	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Estimated cost per person per year	4.84	8.52	6.60	10.56	8.16	13.20	8.52	15.36	10.20	18.12	12.00	17.28	8.66	13.84

1160

and antidiarrhoeal preparations show that these virtually ineffective substances are almost never used.

"Depression" is the second commonest diagnosis in the practice, after upper respiratory tract infection and "anxiety" is the fifth commonest.³ These conditions could be more accurately described as "unhappiness" and "worry" in many patients. Uncovering the cause of their disease—a fairly rare affair for a well-known doctor consulting a well-known patient—is treatment in itself. I have tried not to prescribe for short-lived conditions of this type, particularly in acute crises. Drugs inhibit the motivation for working through the problem and sometimes make matters worse. The most important treatment seems to be that the doctor is available, kind, and interested and that he listens, advises, comforts, reassures, and supports before resorting to psychotropic drugs. These measures should not be demeaned—they are what the patient has come for. Time off work is a potent treatment and is frequently all that is necessary for many minor illnesses. Drugs are not required. When a diagnosis is in doubt I tend to take a second look at the patient before prescribing treatment; the philosophy of "if in doubt, give now!" Thus the prescribing of ampicillin for 10 days to a "possible early pneumonia" when the condition evolves as nothing more than a minor chest pain in an influenza-like illness may be avoided. I try to avoid treating symptoms without a definite diagnosis though I do not always succeed.

I try not to prescribe preparations new to the patient for periods longer than 10 to 14 days. Many people are unable to tolerate drugs and have to discontinue them after a day or two. Where courses of longer than two weeks will be needed, either I see the patient again for further advice and prescription or I tell them to pick up a "repeat."

Many patients need psychological, social, interpersonal, marital, or spiritual counselling. When I realise this I try to offer it, I avoid prescribing and I often share the care with other members of the primary health care team who are frequently better at it than I am—for example, health visitor, social worker, or marriage counsellor. Fortunately, the other team members cannot prescribe drugs so my "inaction" is fortified.

The continuing treatment given to patients after an inpatient hospital stay or an outpatient consultation needs strict revision. Dosage regimens necessary in hospital may sometimes be reduced or stopped at home. Fortunately, my referral rate to hospital is only two-thirds of the national average for inpatients and one-third for outpatients; hence the occasional heavy prescribing by hospital doctors is minimised.

"Repeat" prescriptions need regular review, and records must be available when they are signed. After the recent rise in prescription charges the practice policy has been to order one-month "repeats" for almost all drugs and all patients. This seemed fair, but may account for the slight rise in the number of prescriptions per person in 1981 compared with the previous years.

AVERAGE COST PER ITEM

Since the reduced number of prescription items is mainly due to not prescribing cheap minor remedies for self-limiting physical illness and short-term psychiatric states, the proportion of high cost items (antibiotics, monthly prescriptions for chronic diseases, etc) must be fairly high. Hence, the average cost per item should be much higher than area averages. In fact, it is almost identical, and there are several reasons for this.

I use Professor Rawlin's minipocula which he described in a paper given at the North Tees General Hospital Postgraduate Centre in 1979 (copies available from the Wolfson Unit of Clinical Pharmacology, Clarendon Place, The University, Newcastle upon Tyne NE1 7RU). This consists of a list of 36 reputable, rigorously tested, and commonly used drugs, generically named—that will treat probably over 80% of the conditions seen in general practice. As an example, the drugs for the cardiovascular system are limited to five—trinitrine,

person per year. Also shown is the average cost per prescription item in the county and in my own patients—almost identical. But the rise in the cost of drugs per person per year in the county is steeper and a constantly higher level than my own. My cost per patient averages 6% of the county's average over the six years.

Discussion

My patients receive both infrequent and low-cost drugs despite the proportion of old people in the practice equating with the national average and the practice being in an industrial area with high atmospheric pollution—all factors customarily associated with increased morbidity. The patients may be settling with indignation at the paucity of their prescriptions and suffering unnecessary clinical vicissitudes from "inadequate" medication but I hope not. The stringency stretches back over several years when a detailed patient-satisfaction survey was carried out: only 1% of the patients questioned believed that they were not given a prescription "often enough." The fall in my personal list from 4105 to 3681 in the last five years has resulted from practice policy and not a flight to doctors who prescribe more freely than I do.

As I have got to know my patients during the last 20 years I have become more convinced that when they consult they prefer advice to a prescription. I have often discussed with them my anxieties about the effects of drugs, overdose, interactions, and dependency: I have seen examples of all these in my practice.

Since 1976 all the members of our practice have promulgated a policy of self-care and not prescribing for most minor self-limiting illnesses.⁴ Once patients have seen their own doctor and been examined and reassured, advice on self-care seems to be happily received and increases the likelihood of them caring for themselves without consultation on subsequent occasions. In 1979 the Health Education Council and the DHSS supported this idea with leaflets and posters. These were used extensively in the waiting areas in the practice for several months. My figures for the prescribing of expectorants, cough suppressants,

BRITISH MEDICAL JOURNAL VOLUME 283 31 OCTOBER 1981

propranolol, bendroflumazide, digoxin, and frusemide. I attempt to stick to the drugs in the minipocula and certainly use them first in all new cases. Because there are so few I am reasonably familiar with them. From long usage I know their therapeutic dosage range and their interactions, and my patients have told me of their side effects. I turn to other drugs and new panaceas only when my minipocula drugs fail me, and this seems a rare occurrence. On the whole the drugs in the minipocula are cheap and benign, generally named the least expensive preparation is always dispensed. Imipramine seems to control most cases of depression that I encounter and penicillin V always seems to work in upper respiratory tract infections requiring an antibiotic. I do not adhere too rigidly to Professor Rawlin's choice of drugs in his minipocula but have added several generically named old favourites that I substitute for some of his.

In 1977 15% of prescriptions in England were non-prescriptionary.⁵ In 1979 22% of mine were non-prescriptionary, in 1980 29%, and the figure is expected to be well over half in 1981. This recent steep increase has been produced by simply giving the receptionists a list of generic equivalents which they use when writing out repeat prescriptions. Patients taking continuing medication have repeat prescription cards, and the proprietary names have now been altered to the generic ones.

Many short-term illnesses require only a small quantity of tablets, and I try to minimise the number dispensed. Only 10 or 12 analgesic tablets may be needed for a short-term painful episode; 10 or 12 antihistamine tablets control many acute urticarial reactions. Not only is this economical but in addition many left-over tablets are not cluttering up domestic cupboards.

Conclusion

There is nothing new about my stringent measures; many GPs use them and some better and more effectively than I do. If, however, I had been an "average" GP in Cleveland County my prescribing last year would have cost the National Health Service around £63,000; in fact, it cost about £44,000. A total saving of £19,000 of NHS money certainly seems a good return for only a small amount of effort.

I thank Mrs J Parker, who analysed the data, and my patients who did without a lot of drugs.

References

1. Department of Health and Social Security. *Health and personal social services statistics for England*. London: HMSO, 1978.
2. Marsh GN. *Controlled costs*. *North-east Faculty Newsletter*, 1972.
3. Gray DP. *The key to personal care*. *J R Coll Gen Pract* 1979;29:666-78.
4. Marsh GN. *Kenn-Cassidy P. Team care in general practice*. London: Croom Helm, 1976.
5. Marsh GN. "Curing" minor illness in general practice. *Br Med J* 1977;3:1267-9.

(Accepted 28 July 1981)

ONE HUNDRED YEARS AGO Sir—An intimate friend of mine, who is, I think, inclined to take more alcohol than he is entitled to, alleges, as a reason, the amount of midwifery he attends. He is of opinion that the quantity of beer, etc, consumed, should be regulated by the amount of his performance: the more he midwifery the more beer. My friend is, moreover, of opinion that beer, as it contains comparatively little alcohol, may be consumed in considerable quantities without doing harm. I am, however, of opinion that a substantial meal, or before retiring to rest—Your truly, C. Marsh (*British Medical Journal*, 1881.)