PRACTICE OBSERVED

Practice Research

Use of accident and emergency department by patients from one general practice

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Evidence from the Platt report¹ on the accident and emergency services in 1962 showed that a high proportion of new patients attending accident departments were young men aged 16-29. This was supported by later studies,² and then the Court report³ on the child health services in 1976 drew attention to accidental injury in children.

A rising incidence of children attending accident departments has since been reported in studies from children's hospitals⁴ and in statistics on work load from accident and emergency departments.⁵ It is estimated that one in every three patients seen at accident and emergency departments will be under 16 years of age and that each year 20% of the children in Britain might be expected to attend hospital after accidents. This trend, however, has not been reflected in reports on the accident services from general practice.⁶

I reviewed the patients from an urban practice in the north east of England who attended in accident and emergency departments during one year to find out their age, sex, the pattern of injury, and how they were managed. Patients whose accidents and injuries were treated in the practice without hospital referral were not included.

Methods

The practice has 2821 patients and is in a group practice of five doctors serving an urban population of 17 000 patients. The practice is part of a primary health care team with an appointment system and is confined to an area of about five square miles with a district hospital on its immediate western boundary. The medical centre and the hospital are easily accessible to all patients. The accident and emer-

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gency department that I studied is part of a new district general hospital. Copy-records of each patient's details, treatment, and management are routinely issued to general practitioners. The copy-records of all patients from the practice who were seen in the accident department were collected between 1 June 1980 and 31 May 1981, and the information analysed.

Results

Three hundred and ninety-three practice patients were seen as new patients at the hospital accident department during the year. Seven patients were seen on two separate occasions with different problems, and four patients were seen at accident departments at other hospitals while away from home and are included here. Three hundred and seventy patients were self-referred or were taken directly to the accident department, and only 23 (6%) were referred by the practice.

The age and sex of the 393 patients are shown in fig. 1. There were more male patients in the younger age groups 0-15 and 16-29 years, and more female patients in the age groups 30-59 and 60+. Table 1 gives the number of patients by age who attended the accident department and the percentage of the practice population that they represented: 17% of patients in the age group 0-15 years attended against 12% of patients in the age group 16-60+. Fig. 2 shows the distribution by age and sex of the patients in the practice compared with the figures for England and Wales.⁷ In the practice there were more young people under 16 and fewer people over 60 than in England and Wales. If the attendance rates reported in this survey had affected the population at large then the attendance in the 0-15 age group (42% in fig. 1) would have been 30% in 1 of all patients who attended the accident department would have been under 16.

In fig. 3 the types of accidents and injuries, expressed per 1000 patients a year, are compared for the age groups 0-15 and 16-60+. Most patients attended with accidents and injuries, but acute illness was notable, especially in adults. Soft tissue injuries were common—lacerations and abrasions in patients aged 0-15 and sprains and strains in those 16-60+. Fractures and head injury occurred frequently, as did animal bites, especially dog bites. Eight children were bitten seriously enough to be taken to hospital. Accidental ingestion of medicine was common in patients aged 0-15, often in those under 5,

attendance at the accident department closely approximated to the incidence of accidental injury.

It was disappointing that so few patients—6%—reported to the practice before going to hospital, especially when so many of the problems—67%—were considered to be minor. There is always a doctor or practice nurse at the surgery to see a patient in an emergency, but this service provided by the general practitioner is not being used as much as it could be. Factors that militate against more patients being seen first at the practice may be the apparent infrequency of the appointment system, the patient's habit of taking "accidents to the hospital and illness to the doctor,"⁸ and the accessibility of the hospital. Statistics are now being kept of the number of accidents being dealt with in the practice and the number going to the hospital.

Accidents in children are a major cause of childhood morbidity, their causes are multifactorial,⁹ and their prevention has a high medical priority.¹⁰ Attention should be focused in very young children on avoiding injury at home—especially preventing accidental ingestion of medicine by providing child-proof containers. The large numbers of injuries occurring in school-children as reported in this study might be substantially reduced if attention was drawn to the fact that they are a group "at risk" and that care is required in providing for their needs, as is being shown in the National Play it Safe campaign.

When the Platt report¹ on accident services was published in 1962 a high proportion of patients attending accident departments were young adults aged 15-29, but it now seems that most patients are under 16 years of age, particularly school-children aged 5-15.

Conclusions

Three hundred and ninety-three patients from an urban practice in the north east of England were seen as new patients at the accident and emergency department of a district general hospital in one year. Forty-two per cent were under the age of 16 and attendance at the accident department by young patients (0-15 years) at a rate of 171 per 1000 patients a year was definitely

OF THE OPHTHALMIA, OR INFLAMMATION OF THE EYES.

THIS disease may be occasioned by external injuries, as blows, burns, bruises, and the like. It may likewise proceed from dust, quicklime, or other substances, getting into the eyes. It is often caused by the fogginess of caloric exhalations; as the healing of old sores, arising up from the eye, the suppurating of gentle morning leucorrhoea, or of the sweating of the feet, &c. Long exposure to the night-air, especially in cold northern winds, or whatever suddenly checks the perspiration, especially after the body has been much heated, is very apt to cause an inflammation of the eye. Viewing snow or other white bodies for a long time, or looking idly at the sun, a clear fire, or any bright object, will likewise occasion this malady. A sudden transition from darkness to very bright light will often have the same effect.

OF THE QUINSEY, OR INFLAMMATION OF THE THROAT.

THIS disease is very common in Britain, and is frequently attended with great danger. It prevails in the winter and spring, and is most fatal to young people of a sanguine temperament.

more common than by adults (16-60+) at a rate of 122 per 1000 patients per year. Whereas 10 years ago a high proportion of patients seen at accident departments were young adults aged 16-29 years it now seems likely that those most at risk from accidents and injuries are under the age of 16.

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CAUSES.—In general it proceeds from the same causes as other inflammatory disorders, viz. an obstructed perspiration, or whatever heats or inflames the blood. An inflammation of the throat is often occasioned by emitting long puffs of the covering usually worn about the neck, by drinking cold liquor when the body is warm, by riding or walking against a cold northerly wind, or any thing that greatly cools the throat, and parts adjacent, may likewise proceed from the neglect of breathing, purging, or any cutaneous evacuation.

SINGING, speaking loud and long, or whatever strains the throat, may likewise cause an inflammation of that organ. I have often known the quincy prove fatal to jovial companions, who, after fitting long in a warm room, drinking hot liquors, and singing with vehemence, were (to impute as to go abroad in the cold night-air. Sitting with wet feet, or keeping on wet clothes, are very apt to occasion this malady. It is likewise frequently occasioned by continuing long in a moist place, sitting near an open window, sleeping in a damp bed, sitting in a room that has been newly plastered, &c. I know people who never fail to have a sore throat if they sit even but a short time in a room that has been lately washed.

ACRID or irritating food may likewise inflame the throat, and occasion a quincy. It may also proceed from bones, pins, or other sharp substances sticking in the throat, or from the caustic fumes of metals, or minerals, as arsenic, antimony, &c. taken in by the breath. This disease is sometimes epidemic and infectious.

(Buchen's Domestic Medicine, 1786.)

TABLE 1—Numbers of patients who attended the accident and emergency department (A&E), by age, related to the population of the practice, and attendance rates per 1000 patients a year

Age (years)	No. of patients attending A&E (and percentage of practice population)	No. of patients in the practice	Attendance rates per 1000 patients a year
0-15	187 (17)	796	124
16-29	102 (11)	796	124
30-59	19 (2)	796	24
60+	19 (2)	796	24
All ages	226 (22)	2462	139
16-60+	121 (12)	1666	122

The difference between the attendance rate of children aged 0-15 and that of adults 16-60+ was highly significant ($p < 0.05$). The difference between the attendance rate of children aged 0-15 and that of young adults aged 16-29 was significant ($p < 0.05$). There was no significant difference between the two age groups 16-29 and 30-59. The lower attendance rate of elderly patients 60+ compared to that of other adults was highly significant ($p < 0.01$).

FIG. 1—Distribution by age and sex of practice patients who presented to the accident and emergency department.

FIG. 2—Percentage of patients by age and sex in the practice and in England and Wales.

TABLE 2—Details of patients managed by the accident and emergency department by age group

Age (years)	Hospital admissions	Review in hospital clinic	General practitioner follow-up	Discharged
	No. (%)	No. (%)	No. (%)	No. (%)
0-15	15 (8)	40 (24)	71 (43)	41 (24)
16-60+	23 (20)	48 (22)	103 (45)	52 (23)
Percentage of all ages	9.5	23	44	23.5

while purposeful drug overdose was more common in those aged 16-60+. General medical, surgical, and obstetrical problems were more common in the 16-60+ age group, acute illness being the fourth commonest cause of an adult presenting at the accident department. The only patients with non-accidental injury, despite vigilance in searching for this group, were two 14-year-old girls who had taken drug overdoses. Road traffic accidents were uncommon, even in adults, and no fatalities were recorded in this study.

The distribution of patients managed by the accident and emergency department was remarkably similar in both age groups (table 1). Most patients (67%) needed only simple investigation and treatment and were either discharged or referred to the general practitioner for follow-up; 23% required follow-up in a hospital clinic; 49% at the fracture clinic (20 aged 0-15, 23 aged 16-60+), six at the hand clinic, and 33 for general review next day in the accident department; 9.5% were admitted to hospital; 15 aged 0-15, of whom four had ingested medicine accidentally, two had taken a drug overdose, three had fractures, four had head injuries, and two had febrile convulsions; of the 21 patients admitted to hospital in the 16-60+ age group, eight had acute general medical problems, seven had taken a drug overdose, four had fractures, two had head injuries, and two had been in road traffic accidents. Of the 167 patients aged 0-15 who attended the accident department (table 1), 75% were schoolchildren aged 5-15, 66% of these were admitted to hospital and 92% sustained fractures.

TABLE 3—Details of patients aged 0 to 15 years attending the accident and emergency department

Age (years)	No. (%) of patients	Male female	Hospital admissions	Fractures
0-4	11 (24.5)	3 (1)	1	2
5-15	126 (75.5)	3 (1)	10 (66.7)	24 (92.4)

Discussion

Young patients aged 0-15 years from one general practice attended the accident department at hospital much more frequently than patients in the age groups 16-29, 30-59, and 60+ or in the combined age groups 16-60+. The findings that nearly one child in five attended the accident department during the year (17% in the 0-15 age group) and that 30% of the patients seen at accident departments will be under 16 years of age are similar to those reported from South Glamorgan¹ and Sheffield.¹² In this study, however, 75% of patients in the age group 0-15 were schoolchildren aged 5-15. Most patients sought advice from the accident department about accidents and injuries rather than about illness and general medical problems and this was especially so for young patients in the 0-15 age group when

Organising a Practice

Organising health education

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The highways and byways of general practice are littered with lost opportunities for health education. The doctor may not see the need, or may see it and not meet it. The patient may not accept that there is a problem and rebuts the doctor's attempts at health education. As providing health care becomes more complex and expensive, the patient and doctor become partners in maintaining health and preventing and managing disease. Both seek and impart facts about health and disease so that both will benefit. How does the general practitioner organise the promotion of health, advice about prevention and management of disease, and the correct use of medical services in his practice—all of which may be considered as health education?

The consultation

General practitioners have great opportunities for educating patients about health during the consultation. The disease incident that the patient presents with may provide opportunities for health teaching, subsequent prevention, and the management of the current problem. There are obvious topics for discussion when the patient is a smoker with an episode of bronchitis, but the common problem of the febrile child may lead the doctor to check on the immunisation status of the child, give advice about nursing management, and discuss the use of aspirin versus paracetamol, the non-prescription of antibiotics in viral infections, exclusion from school or nursery, and subsequent action by the parent if the fever does not abate. The possibility of side effects occurring from prescribed medicines and the duration of treatment should be mentioned.

Many general practitioners already do this without realising that it is health education, taking a common-sense view that it is part of their normal practice to give such advice. Some effort must be made, however, to check that such details are not neglected, and no consultation is complete until some health education has been given. Depending on the doctor's beliefs and practice, the doctor may (a) dispel widely held myths about health: "can't get pregnant for the first time," "acid foods" bad for rheumatism," "coated tongue means you're constipated," and so on; (b) carry out screening procedures to detect potential problems—deafness, high or low blood pressure, glycosuria and albuminuria, and cervical cytology; (c) identify smoking habits and record in the notes the number of cigarettes smoked so that the question may be asked again at the next consultation; (d) identify the need for contraception in both men and women; (e) weigh the patient and give advice about diet in obviously obese patients.

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The practice

It is vitally important that the other doctors in the practice agree on the approach to important health education topics such as smoking on practice premises, writing repeat prescriptions, prescribing placebos, and prescribing self-limiting illness such as the common cold. No member of the practice team should smoke on practice premises since precept is important, and attitudes about the use of seat belts, for example, should be discussed and a policy formulated.

Health education is most likely to flourish when the patient recognises that there is concern for his well-being and care when he is unwell, and any practice procedures that seem to militate against this should be reviewed. Unpunctuality by anyone on the staff—that may cause long waits by patients, for example—is most unhelpful to the cause of health education.

THE TEAM

There must be a co-ordinated effort by the practice team to consider their individual roles in health education. The health visitor is the specialist and should be the innovator in health education and stimulate the other team members. She is the link between the practice and sources of help in the district health authority, and is likely to be able to liaise with the health education officer regarding health education campaigns. Nurses and midwives, like general practitioners, have ideal teaching situations during their work. Morbidity recording will identify common or growing problems as targets for health education.

FORMAL TEACHING

In addition to the opportunities for health education in the consultation, there is scope for more formal teaching. Age/sex registers will identify the number of patients in groups that need

health education—menopausal women, teenagers leaving school, elderly patients—who can be invited to attend group teaching sessions at the practice. These groups can be made up of patients with similar problems—backache, diabetes, arthritis—who would benefit from mutual discussion and teaching. Such teaching can be undertaken by the team or by invited speakers. Health teaching is also a prominent feature of screening patients at risk from among those in antenatal clinics, well-baby clinics, well-woman clinics, elderly patients and the contraceptive clinic. Such measures would be helped if general practitioners could use PRESTOL facilities when sending such invitations to patients.

PATIENT GROUPS

Patient participation groups are associated with some practices in England and Wales,¹ and their advice on health education topics for the practice, or on practice organisation, can be sought with considerable benefit to the practice.

PRACTICE LEAFLETS AND BOOKLETS

Some practices have produced booklets on such topics as health education, use of services, minor illness, and care of the elderly. The booklet produced by the practice is likely to be more acceptable and useful in that practice than attempts to produce a uniform edition for every practice and is enthusiastically received by patients. A practice newsletter is also useful for health education.

OTHER SOURCES OF HELP

The health education officer could be the practice's best friend for advice, providing material, evaluating health education in the practice, and providing visual aids and projectors. Unfortunately, health education officers are too thin on the ground in most areas to be concerned in individual practices, but this should not prevent general practitioners making the effort to contact their local HEO. In the reorganisation of the National Health Service, health education is a priority for finance for health education at district level have not been defined. General practitioners should make their concern about the financing of health education services clear to the district medical officer.

The Health Education Council espouses the cause of health education by general practitioners in many ways. Seminars are held throughout England and Wales. Materials, such as posters, leaflets, and booklets, are constantly being reviewed for use in general practice. Teaching sessions in broadcasting for doctors interested in appearing on medical programmes on local radio or on phone-in programmes are organised. Voluntary bodies such as Action on Smoking and Health (ASH), the Chest, Heart and Stroke Association, and the Diabetic Association produce material for use in general practice.

Health education in the Birchfield practice

From 1960 the idea of giving formal health teaching to patients has attracted steadily increasing interest. I asked the ethical committee of the BMA for advice on teaching patients in small groups on the practice premises. The advice was that the meetings should be advertised only in the waiting room of the practice, that attendance should be limited to our patients and proved by the production of a medical card with our name on it, and that our neighbouring colleagues should be consulted about the propriety of us holding such sessions. (When consulted, our colleagues expressed anxiety about our holding such sessions.)

The first topics presented were of general interest—cancer, tonics, sensible clothing. But over the years we have aimed at

target groups with similar problems—the menopausal women, deaf patients, patients with back problems, diabetic patients, patients with arthritis, those with smoking problems. We invite groups of patients by letter, and 40 to 50 patients usually attend. We aim to teach self help and about help that we or our specialist colleagues can give, and give details of associations for those with such problems.

Our Patients' Association help to choose the topic, provide refreshments, and plug the association's activities at the meetings. Some pharmaceutical companies have audiovisual material for such meetings, and we are well provided on good paper. Patients who attend the clinic for the over-65s have been given the booklet. A booklet for mothers with children under 5 is distributed free, and printing costs for this have been paid for by a local organisation.

I think that the leaflet is only a support for teaching by the practice team and not a substitute. How to have leaflets readily available and available in the consulting room is a problem but a recent compendium produced by Professional Counselling Aids Ltd is helpful. Leaflets are produced by the Diabetic Association and Muscular Dystrophy, for example, and we recommend that patients join such groups.

Someone in the practice should assume overall responsibility for the health education programme, for displays and for meetings. It is essential to keep the subject in the front of the team, to keep a fresh approach, and to evaluate the results.

Does it work?

Russell² has shown that general practitioners telling patients not to smoke is more effective than anti-smoking clinics, and Ley *et al*³ that communication can be improved by, for example, repeating instructions to patients. Small group discussions on the menopause⁴ and diabetes have been effective, and booklets have been shown to increase knowledge and change behaviour.^{5,6} We have introduced a system so that babies under one year of age can be seen at any time, which does not increase the work load in the practice.⁷

General practitioners should inform patients adequately about their presenting problem and its management and subsequent prevention. Doctors will decide for themselves what additional health education can be added on at the consultation or carried out formally through booklets or leaflets for patients or at patient meetings. Such small changes aimed at correcting unhealthy behaviour or encouraging healthier behaviour would produce an appreciable effect on the health of the nation. General practitioners should not ignore this important aspect of their profession.

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extreme social disruption, should be referred, but there is no clear guideline for less severely ill patients. Kessel⁸ suggested that two criteria should be used: clinical severity, which includes both psychiatric distress and the degree of social disability, and failure to respond to treatment. Clinical experience has confirmed his observation that patients are often referred before the GP has fully explored all of the possible ways of managing the patient, or before treatments have had time to take effect—for example, with tricyclic antidepressants. To these, a third clinical condition should be added: patients for whom the GP cannot plan treatment, because he is uncertain what the patient's problem is or because a treatment that is unavailable in general practice is required—specialised behavioural therapy, for example.

There are other reasons for referral that are not directly concerned with the patient's clinical state: a patient with chronic neurotic symptoms who attends frequently. The referral is not so much for diagnosis and treatment, but to give the doctor a break. He may be seeking either to share the burden of a difficult patient, or to be free of it, at least for a while. Every psychiatric outpatient clinic has some long-term attenders who receive treatment that is grandiosely referred to as "supportive psychotherapy." Usually the psychiatrist is providing nothing more than the GP could provide equally well. This is not to say that such patients should never be referred, but only that the GP should be clear in his own mind as to the reason for referral and not allow such a patient to have unreasonably high expectations about referral to a psychiatrist.

Communication between psychiatrists and GPs about referred patients are usually by letter. The quality of referral letters is often an emotive topic. A referral letter that I saw recently—"Phobias"—can negate the positive impression derived from a series of helpful letters. Similarly, psychiatrists' reports are often

considered to be lengthy, largely irrelevant, and ridden with jargon.

GPs and psychiatrists are often unaware of what the other wants from a written communication. I have studied psychiatrists and GPs with regard to their needs from referral letters and reports and compared the results with information in a series of letters and reports.⁹ Many referral letters contained the required information, whereas many of the psychiatrists' reports contained information that the GP did not want. There is thus room for improvement on both sides, though one comment made by psychiatrists then and since is that in addition to the provisional diagnosis it is helpful to know the reason for referral. The GP should say whether it is advice on the diagnosis and management that he wants or whether he wants the psychiatrist to take over. Making the requirements of a referral explicit could go a long way towards reducing dissatisfaction.

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Overcoming Isolation

Contributions to the series "Overcoming Isolation" are welcome for consideration.

Lichfield: Academic support practice

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The Book of Common Prayer speaks of the "quick and the dead." In general practice one might differentiate more accurately between the quizzical and the dead, for the doctor who does not question what he does and why he does it is moribund, if not already decomposing. Thus in 1979 after seven years as a GP trainer I took sabbatical leave to ask a few questions on continuing education for established principals.

Most education appeared to be offered in postgraduate centres in hospitals. Although they provide valuable facilities, they are nevertheless away from the environment in which a general practitioner normally works, and present problems of access, travelling, and sharing. They tend to be large and formal with fixed seating for old style lectures. They are rarely used to capacity, and meetings are often biased towards the hospital. Once session 63 attendances were no longer necessary to ensure the receipt of stipend payments, attendances began to drop.¹

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yet 80% of postgraduate training for the general practitioner goes on in them, relying heavily on the system of formal lectures.² About 80% of general practitioners also seem not to use their local centres, and therefore about 80% of patients must be relying on doctors whose arrangements for continuing education are unknown. Postgraduate education has been treated for too long as an optional extra when it should be part of the job. It follows that the best place for it to take place is in general practice itself, where one can "discuss business where work is done."³

A prototype for a postgraduate centre based in general practice has been built on to the Saint Chad Health Centre at Lichfield. The health centre was built in 1973 and houses four principals with two trainees. The postgraduate extension was added in 1981 and its second phase—the bar and seminar room—is now nearing completion. The centre has been called an "academic support practice."⁴ It consists of a foyer, cloakroom and toilet, bar for refreshments, library doubling as a conference room for 25 people, and a seminar room doubling as a "club" room. A two-way mirror for observation in a

The GP and the Specialist

Psychiatry

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It has been said that of all specialists the psychiatrist has most in common with the general practitioner because they share a holistic approach to the patient, and because of a common interest in the social aspects of illness. If this is so, it is not always apparent in their professional relationships. This may be due in part to the mistaken view that psychiatry is an esoteric and jargon-ridden discipline, a view that is reinforced by the activities of some psychiatrists. The late Richard Asher drew attention to this in 1949: "A physician faced with a patient exhibiting some functional symptoms is likely to feel that the origin of the simplest psychoneurotic symptoms lies buried in an uncharted swamp in which only the expert can poke with impunity—a swamp crawling with complexes and repressions, where nothing is what it seems and everything symbolises something indecent. This is a foolish attitude to take."¹

Some psychiatrists, on the other hand, may take the view that treatment of psychiatric disorders by general practitioners is incompetent and inefficient. Apart from being insulting, this neglects the fact that the bulk of the psychiatric morbidity in the community at any one time is managed entirely by general practitioners, without recourse to psychiatric referral or assistance. None the less, published reports and clinical experience alike point to certain areas in general practitioner psychiatric care where there is clearly room for improvement. I will discuss these under three headings: assessment, management, and referral.

Assessment

Obviously, psychiatric disorder cannot be treated if it is not recognised. Research studies have shown that general practitioners fail to identify about one-third of the psychiatric morbidity that presents to them.^{2,3} This is due in part to the doctor's attitudes, personality, and interviewing style⁴ and in part to the way in which the patient presents the problem. Goldberg and Blackwell⁵ convincingly showed that the bulk of the hidden or missed psychiatric morbidity was in patients who, for various reasons, presented their emotional distress in physical terms. As well as patients presenting new physical complaints, such as headache and dizziness, they cited cases where the exacerbation of a long-standing physical complaint, such as pain, resulted from emotional problems.

Part of the problem arises from a lack of awareness of the possible emotional aetiology of physical symptoms (a problem shared by hospital physicians)⁶ and part from a failure to attend to what the patient is trying to communicate. Furthermore, there is the need to adopt models of illness that are not exclusively medical.⁷ The doctor's understanding of a middle-aged, recently bereaved woman who complains of depressive symptoms is

greatly increased when further inquiry reveals that she has recently moved house to a new community, has made no friends there, and cannot visit her family as often as before.

Management

Most of the criticism of the way general practitioners manage patients with psychiatric problems centres on the use of psychotropic drugs. Though this criticism may be exaggerated, few would claim that there is no room for improvement. A psychotropic drug may be prescribed routinely in response to a psychological complaint without sufficient consideration being given to other ways of managing the patient's problem. Much psychiatric disorder in the community is short-lived, and many such patients can perhaps be counselled and supported through a crisis rather than be given drugs. Furthermore, there is little evidence that long-term treatment with benzodiazepines is beneficial, but the chances of getting a patient to stop taking psychotropic drugs decreases sharply with the duration of treatment.⁸ Other problems of management—particularly in patients who are subsequently referred to psychiatrists—occur when patients are taking more than one drug and when the regimen of tricyclic antidepressant treatment is inadequate.⁹ There is no justification for prescribing two or more benzodiazepines at the same time to a patient, and there is no need to give benzodiazepine tranquilisers by day and a benzodiazepine hypnotic at night. Judicious spacing of the tranquilliser dosage—that is, the last dose to be taken at night—will do just as well.

Psychiatrists are often asked to see depressed patients who, it is claimed, have not responded to antidepressants. But often the patient has been receiving an inadequate dose. I recently saw a patient who had "not responded" to amitriptyline 10 mg at night. Although the response depends on serum drug concentrations, doses of less than 75 mg a day are unlikely to relieve depression. Low doses of tricyclic antidepressants may relieve anxiety, but if that is the aim of treatment a tranquilliser should be prescribed.

Referral

Much progress has been made since 1945, when an unpublished Royal Medical-Psychological Association document opined that: "It is a sound rule to refer (to a psychiatrist) any patient who seeks advice for purely psychological symptoms, such as fears, depression . . . the same is true of patients worried or partially incapacitated by vague somatic or psychosomatic symptoms . . . roughly the same rules apply to the chronic neurotic with an acute exacerbation of his symptoms." Such advice, if strictly followed, would have resulted in psychiatrists seeing vast numbers of patients who did not need specialist help. Implicit in that sentence is the notion that referral can be classified into those that are appropriate and those that are inappropriate, but this is clearly an area in which opinions will differ. Most psychiatrists would agree that patients who are acutely psychotic, especially if there is a risk of suicide or

consulting room completes it. The bar opens into both the foyer and the seminar room. It is a small, intimate place, geared for a greater level of personal commitment by local general practitioners: a club atmosphere is encouraged. The unit is self-contained, and, though it is normally entered through the health centre, it can be shut off at night from the health centre with private access for general practitioners through a side door. General practitioners in the area have their own keys and are thereby free to use its facilities at any hour of day or night.

The programme of the centre is determined by a committee of general practitioners appointed from each of the local practices by their own practices to represent their interests. It is as near "government of the people, by the people, for the people" as possible. The committee is free to arrange what meetings it wishes and their format, content, timing, and duration. The intimate knowledge each representative has of his own practice and partners ensures that programmes are relevant and therefore useful. If the representative cannot attend a meeting, the practice sends a substitute.

A postgraduate centre in a general practice, drawing its lifeblood from the daily work of an ordinary practice, is both exciting and down to earth. In such a setting established principals can be encouraged to meet together not as a penance but for pleasure, and unlike many a centre based in hospital its small scale is more agreeable for the occupants. In such an atmosphere work in small groups in seminars, workshops, Balint-style sessions, and "buzz" groups can flourish. Lectures still play a part, given by visiting specialist colleagues—but the difference is that the consultant does the visiting and not the general practitioner: the GP is on home ground. Meetings are therefore less formal—with much more discussion, interruption, and exchange of ideas. The lecturer's podium disappears; there is nothing to hide behind.

The library and conference room with the television set linked to Prestel and the cupboard which hides the skeleton.

Although many individual practices have their own postgraduate meetings, they lack the necessary stimulus of cross-fertilisation from other practices. Practices, like people, become set in their ways. The academic support practice, bringing together members of different practices of different types, can rejuvenate an inward-looking sterility of approach and ideas. The interaction of different skills and expertise stimulate ways of thinking that might have slumbered on in a more parochial setting. Different approaches sparking each other off are flint and steel to the dry logs of learning.

The library is geared specifically for general practice, with books, audio-cassettes, video-cassettes, x-ray films, slides, and specimens. A Prestel-linked television set is provided for access to government statistics and for videodata service with its "medical profession only" pages (including those of the *BMJ*) and case studies. This room is used more than the others "out of hours"; holding group meetings is being looked on more and more as part of the day's work. A video camera and recording system can be operated on mains or battery and are portable, for use in any room or anywhere in the catchment area.

The seminar room will be the hub of small group work. Marinker writes of the newer methods of teaching as "things which may excite or terrify."¹⁰ They are much more likely to excite when used in the familiar framework of an ordinary practice among local colleagues. The steady, increasing participation of general practitioners by personal invitation from the centre or through other attenders should substantially improve on the 20% attendance achieved at the larger centres. Since absences will be more noticeable, follow-up can be carried out by the group.

The concept of the academic support practice is the result of an attempt of local general practitioners to organise postgraduate education as an integral part of the job at the same time as relieving the intellectual and social isolation of many GPs from each other: an attempt to work and to learn within the community.

References

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