health education—menopausal women, teenagers leaving school, elderly patients—who can be invited to attend group teaching sessions at the practice. These groups provide groups 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 PRESTOP 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 likely to be financed 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 a 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 the material should be vetted beforehand for suitability and lack of promotional material. The Patients' Association have purchased an overhead projector for use in the practice.

Two members of the Patients' Association are skilled graphic artists and designers. We have produced a booklet for the practice for patients over 65. A further booklet is in production to teach patients what to do in emergencies. These booklets cost the practice about 20p a copy, and are well produced on good quality 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, but 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. Kessel¹ 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, either 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.² 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

L T HARRINGTON

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

PAUL WILLIAMS

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 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.

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.

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

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