substituted salicylates may lead to the development of an effective oral agent that is not associated with the side effects of sulphasalazine.\(^1\)

Two other drugs have been investigated as possible treatments: azathioprine and disodium cromoglycate. Azathioprine (2.5 mg per kg body weight) has been added to corticosteroid treatment of acute ulcerative colitis but little benefit was observed. Azathioprine may, however, be of marginal use as a prophylactic treatment in patients who relapse frequently.\(^2\)

As a supplementary treatment to patients with acute colitis unresponsive to steroids or sulphasalazine disodium cromoglycate was of no value in inducing a remission\(^2\); as a maintenance treatment disodium cromoglycate was less effective than sulphasalazine and no better than placebo.\(^3\) For the time being, then, despite the high incidence of dose-related side effects, sulphasalazine remains the drug of choice for the prolonged treatment of patients with ulcerative colitis in remission.


**Psychiatry in the general hospital**

Twenty years ago Shepherd and others found that 38 of 100 consecutive medical outpatients at a London hospital had a psychiatric disability without any sign of physical disease. Twenty-one of the patients had neurotic reactions or personality difficulties and 17 had depression. A further 13 patients were both psychiatrically and physically ill. Many other examples could be quoted. More recently Maguire et al judged that 53 (23%) of 230 consecutive medical admissions had a psychiatric illness—after those who had attempted suicide or who were too unwell to participate in the study had been excluded from the sample. Goldberg's general health questionnaire and the Standardised Psychiatric Interview were used to determine the presence of psychiatric illness, and diagnoses of depressive illness or anxiety state were made for 36 of the affected individuals. In 17 of this subgroup the mood disturbance seemed to represent an adverse psychological response to physical disease.

Yet despite this weight of evidence general and specialist physicians still show a high threshold of suspicion for formal psychiatric disorder. Brody has claimed that in medical outpatients in the United States interns and residents missed one-third of the psychiatric disturbances that were detected by means of the general health questionnaire. Physicians here are as reluctant to ask for a psychiatric opinion; in the two British surveys only one in 30 medical and surgical outpatients and one in 10 inpatients were examined by a psychiatrist.

Estimates of numbers vary from one study to another but the overall conclusions are consistent: many more patients are assessed as having psychiatric disorders than are referred to psychiatrists. What are the explanations offered? The extent of psychiatric morbidity in general hospital populations may have been overestimated for methodological reasons; the organisation and quality of local psychiatric services may be inadequate to meet general medical demands; or most psychiatric disorders identified in these surveys may be too benign to give physicians cause to seek a psychiatric opinion.

A more realistic explanation is that many consultant physicians seem to be sceptical about the effectiveness of psychiatric diagnosis and management that they resist referring patients to psychiatrists. Steinberg et al have published the findings of a North American investigation that showed that attending physicians refused to accept their junior staff's recommendations for psychiatric referrals in over half of a series of medical inpatients with "major emotional problems" related to their illness or treatment. In 30 of the 50 cases where there was resistance the physicians either minimised the relevance of psychiatric symptoms to the medical management or were unaware of the benefit that could have resulted to the patient from a psychiatric intervention. In a further 12 instances the physicians stated that a psychiatric consultation might make their patient angry or emotionally upset and so impair the doctor-patient relationship. Similar views are met in Britain. Mezey and Kellett sent a questionnaire on "reasons for not referring a patient to a psychiatrist" to all 106 non-psychiatric clinical consultants who were on the staffs of six general hospitals in a defined area. Eighty-eight consultants completed the form and, of the 10 reasons given, the one that influenced most of them (40) against a referral was the belief that the patient would dislike being referred to a psychiatrist.

The next most common reason was that the patient would be put at some disadvantage by being labelled as a "mental case."
Few consultants (17) agreed that the treatment of neurotic patients was "the job of any doctor." Altogether the clinicians were dissatisfied with the existing psychiatric services. These research methods may be criticised but the results confirm popular prejudices about psychiatry and psychiatrists.

Against this background, what are the prospects for psychiatry in the setting of a general hospital? Most of the psychiatric disorders that present in hospital departments probably require no more special skill than could be provided by a physician and a social worker. Indeed, much of current thinking on the psychosocial assessment of patients who have attempted suicide,1 the most common psychiatric condition in hospitals, is in keeping with that view. Subtler sorts of psychiatric distress, however, come less easily to attention in the medical setting. If general physicians are to undertake more responsibility for the psychiatric care of their patients they will have to develop a greater sensitivity to abnormal mental states in the context of physical illness. Meanwhile psychiatry and psychiatrists are set to stay in the medical doldrums. "Liaison" psychiatry—the subspecialty that provides psychiatric assessments on patients with physical disorders—lacks a coherent theoretical foundation. The conclusion, clearly, is that in the future all hospital doctors should understand and apply the principles and practice of psychological medicine.


The Comptroller and Auditor General also found wide variations in staffing numbers between regions and areas that could not be explained by differences in the conventional measures of work load, such as bed numbers and relative mortality ratios. For example, in relation to weighted population the South-east Thames region in 1978 was employing 17% more nurses, 23% more administrative and clerical staff, and 37% more ancillary staff than the East Anglian region. Even larger variations were found among hospitals. A study of 18 district general hospitals showed that one employed three times as many catering staff and twice as many porters per 100 beds as others.

On asking the health departments the reasons for such disparities the Comptroller and Auditor General received conflicting replies. On the one hand he was told that attempts were being made to reduce the numbers of certain categories of staff; on the other he was informed by implication that areas and areas with high staffing figures represented standards of provision to which other localities should aspire as their revenue allocations are increased through the reallocation machinery.

Lurking behind this conundrum is a conflicting approach to the evaluation of manpower trends. Judgments about staffing levels that are based on comparisons over time or between areas tend to regard manpower as an absolute measure without too much regard for the service outputs produced by it. The belief that a 46% increase in administrative and clerical staff between 1971 and 1979 is inherently a bad thing reflects that approach and encourages the view that reductions in certain categories of staff are intrinsically desirable, whatever impact they may have on the balance or efficiency of services.

An assessment that takes account of what people in different categories actually do may lead to different conclusions. The Comptroller and Auditor General found a simple illustration of this: one hospital with a high ratio of catering staff had a centralised catering system that made heavy use of catering staff but saved on nursing time. The Comptroller and Auditor General commented that "comparisons could therefore be complex, lengthy, and uncertain exercises." Precisely so; but until manpower is seen as a means to the wider end of service provision, not as an end in itself, judgments about the supply, distribution, and balance of different categories of staff will remain planted in the quicksands of subjective opinion.

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Misleading manpower statistics

On 23 February, BBC television began a new series of the comedy programme Yes Minister with an episode about a new hospital employing some 500 busy managers, administrators, and secretaries but, owing to lack of funds, without a single patient, doctor, or nurse. The episode played on the popular belief that the public services in general, and the health services in particular, are overadministered to the detriment of those whom the services seek to benefit.

Some ammunition to support that belief can be found in the latest report of the Comptroller and Auditor General. In the period 1971-9 total staff numbers in the NHS increased by some 174 000, or 23%. Within that total administrative and clerical staff increased by 46%, and professional and technical staff by 50%. In comparison, medical staff numbers rose by 31% and nursing and midwifery staff by 25%. Ancillary staff, including catering, domestic, and portering staff, increased by only 3%.

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Tardive dyskinesia

The introduction of effective antipsychotic drugs in the 1950s vastly improved the clinical management of psychotic patients. These drugs rapidly control psychotic symptoms in most cases and prevent recurrences in schizophrenia; but they also often produce unwanted neurological effects early in treatment (dystonias, Parkinsonism, akathisia). Long-term treatment with antipsychotic drugs is also associated with abnormal movements described as tardive dyskinesia. Public disquiet in the United States of America about this adverse drug effect led the American Psychiatric Association to set up a task force to investigate the reaction. Its report provides an excellent account of the condition and contains much sound clinical advice.1

Tardive dyskinesia includes orolingual dyskinesia, chorea, athetosis, dystonia, and tics, but not rhythmic tremor. It