The use of psychotropic drugs in general practice

A report of a year's survey

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SUMMARY. All the psychotropic tablets prescribed by a general practitioner in one year are itemised. The patients who received them are separated into diagnostic groups and their treatment is analysed by the number of attendances, prescriptions, and duration of therapy. Hospital referrals and overdoses over a longer period are recorded. My policy in psychiatric conditions is indicated.

Introduction

With some thought and reading the general practitioner can form a logical and coherent policy for treating most of the common conditions he meets. In contrast, of late I have felt lost and uncertain in deciding how to handle those patients whom my father would have dismissed with some contempt as ' neurotics'.

I qualified in London in 1946 and had been taught like him to differentiate organic diseases worthy of serious endeavour from functional complaints which were to be treated by physiological explanation and a placebo. In house jobs, the Royal Navy, a trainee assistantship under a first-rate doctor (with a D.P.M., but a scepticism of psychological treatment) and my early years in practice here, I had adopted this approach and had felt no need to question it. It worked and my neurotics presented few problems: they were diagnosed and dismissed with explanation and Mist.gentian et bromide, 30 ml tds, which was only repeated for two or three bottles to ensure that they did not develop bromism or become ' chronics ' ; the patients at least seemed content; there were no suicidal attempts and only an occasional referral to hospital, usually for schizophrenia or a rare deep depression requiring electroconvulsive therapy.

Then I was lent M. Balint's *The Doctor, His Patient and the Illness* (1964) and more patients started coming for more talk. Then the pharmaceutical industry began producing psychotropic drugs leading me to dispense them and the patients to expect them. More and more patients were presenting and I was diagnosing ' anxiety ' and ' depression ' more and more often for there were now treatments to hand to fit the labels. Manifestly the majority of these patients were not suffering from a life-endangering disease, at least until I gave them tablets and the temptation of an easy demonstration of suffering.

History is the story of man experiencing hazard, stress, and suffering in all parts of the world and overcoming them generation after generation without synthetic drugs until a few years ago in the few rich countries. The wheel had turned full circle and I wondered if perhaps the first approach might not be as good or better than the last with lower cost and effort and a prophylactic effect as well.

To attempt a rational conclusion it was necessary first to know what I was doing. This paper is a record of my findings.

Method

All psychotropic drugs prescribed in tablet form for my patients between 1 March 1971 and 29 February 1972 were recorded; drugs used solely for treating epilepsy such as

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phenytoin were excluded, but phenobarbitone which might be used in other conditions was included even in cases of epilepsy.

A separate filing card was issued for each patient prescribed a psychotropic drug and on this my secretary entered name, age, and sex and recorded each prescription with date, drug, dose, and quantity.

This is a dispensing practice so that all prescriptions are retained thus affording a simple means of checking after each surgery that the drug cards were fully completed.

At the end of the survey period the National Health Service record envelope of each patient with a drug card was examined and from this the diagnosis, duration of treatment, and number of consultations were abstracted and entered on the drug card. It was impossible to separate consultations solely related to the condition being treated with psychotropic drugs from those for other conditions occurring concurrently. Thus all attendances from the start to finish of each treatment were included.

If a patient was given a single prescription or the final one of a course the duration of treatment was estimated by dividing the number of tablets given by the daily dose advised. In the case of tranquillisers which the patients were advised to take as necessary this estimation was arbitrarily based on the assumption that the tablets would be taken three times a day.

Unfortunately the records of a few patients who moved out of the district were not fully abstracted so that some details are missing. These omissions are noted beneath the various tables.

The information on the drug cards provided the material for the results tabulated below.

The practice

This is a dispensing rural practice near Bristol and Bath. The partners live in separate villages running their own functionally separate practices, but helping each other in off-duty and holiday periods. This paper relates to my section of the practice which is based on consulting rooms in my own residence, where I am helped by one secretary.

TABLE 1
AGE AND SEX DISTRIBUTION OF THE PRACTICE

Age	*0–*	*15–*	*25–*	*35–*	*45–*	*55–*	*65–*	*Total*
Male	293	163	151	167	127	117	110	1,128
Female	286	150	167	167	148	117	146	1,181
Total	579	313	318	334	275	234	256	2,309

Most of the patients live in two villages one of which has a large private-enterprise housing estate which has been built in the past 14 years. The indigenous population has the advantage of extensive family relationships and life-long acquaintances and friends. The newcomers have migrated from towns, the majority as young couples, so that they have no local family or friends and often remain strangers to the natives for years. There are a primary and junior school, a number of shops, two churches, a chapel, a flourishing women's institute, and a football club.

Drugs prescribed

Of my patients, 248 (10·7 per cent of the population) received psychotropic drugs, but many were given more than one class; 24 different preparations were prescribed

TABLE 2

THE DRUGS PRESCRIBED: PROPRIETORY NAME AND DOSE; NUMBER OF PATIENTS GIVEN EACH PREPARATION; NUMBER OF PATIENTS GIVEN A SINGLE PRESCRIPTION; TOTAL NUMBER OF TABLETS; NUMBER OF PRESCRIPTIONS; AVERAGE NUMBER OF TABLETS PER PRESCRIPTION

	Drug	*Dose (mg)*	*Number of patients*	*Patients with single prescriptions*	*Number of tablets*	*Number of prescriptions*	*Average number of tablets per prescription*
Antidepressants	*' Tryptizol '	25	73	21	23,252	301	77
		10	7	2	1,459	21	69
	*' Tofranil '	25	3	0	2,732	27	101
		10	1	1	14	1	14
	' Lentizol '	50	1	1	30	1	30
	' Pertofran '	25	1	0	2,350	15	157
	' Triptafen '	forte	1	0	150	3	50
		DA	1	0	100	2	50
	*' Nardil '	15	5	0	1,968	37	52
	' Parstelin '		1	0	250	4	63
			94	25	32,265	412	78
Barbiturates	*' Sod.Amytal '	200	6	5	155	8	19
		60	29	20	2,377	47	51
	*' Seconal '	100	2	0	240	4	60
		50	1	0	620	7	89
	' Nembutal '	100	1	0	335	5	67
	*Phenobarb	60	2	0	1,398	8	175
	et theobrom.	30	33	22	4,300	60	130
			1	0	420	4	105
	' Carbrital '		1	0	590	6	98
			76	47	10,435	149	86
Other hypnotics	' Mandrax '		4	3	290	7	41
	*' Mogadon '	5	12	5	1,828	40	46
	' Tricloryl '		1	1	35	1	35
			17	9	2,153	48	45
Minor tranquillisers	*' Librium '	10	52	34	3,822	97	39
		5	32	13	4,273	69	62
	*' Valium '	5	16	6	3,489	54	65
		2	11	4	3,319	40	83
			111	57	14,903	260	57
Major tranquillisers	*' Fentazin '	4	7	3	1,350	22	61
		2	4	2	1,362	12	110
	*' Largactil '	50	3	1	440	8	55
		25	15	5	2,977	49	61
	' Melleril '	50	1	0	720	6	120
		25	1	0	82	2	41
		10	1	0	390	8	49
	' Stelazine '	5	1	0	120	2	60
		2	1	0	62	3	21
	*' Stemetil '	25	2	2	90	2	45
		5	16	14	1,042	18	58
	*' Serenace '	0·5	3	0	740	10	74
			55	27	9,375	142	66

* Denotes regularly used by me.

TABLE 3

SUMMARY OF TABLE 2

	Number of patients	Number given single prescriptions	Total number of prescriptions	Number of tablets prescribed	%
Antidepressants	94	25	412	32,265	*46·6*
Minor tranquillisers	111	57	260	14,903	*21·6*
Barbiturates	76	47	149	10,435	*15·1*
Major tranquillisers	55	27	142	9,375	13·6
Non-barbiturate hypnotics	17	9	48	2,153	*3·1*
All classes of drug	353	165	1,011	69,131	*100*

to 353 patients. Those regularly used and therefore familiar to me are indicated by an asterisk; these 13 preparations were given to 335 patients. The remaining 11 were given to 18 patients most of whom had joined the practice while taking them and were reluctant to change, but some were prescribed on the recommendation of local consultants.

One hundred and sixty-five of the 353 patients were given a single prescription including 25 of the 94 patients prescribed antidepressants, but in 12 of these the diagnosis was dubious.

At the time of this survey ' Sodium amytal ' 60 mg was being used as a minor tranquilliser and 17 of the 29 patients prescribed this drug were given it for this purpose; the remaining 12 patients were given it as an hypnotic. This drug is listed as a barbiturate in tables 3 and 5.

During the survey year a total of 69,131 tablets were prescribed in 1,011 prescriptions; 47 per cent of the tablets were antidepressants, 35 per cent tranquillisers and 18 per cent hypnotics. During 1971 in England and Wales 3,000 million tablets were prescribed in 47·8 million prescriptions (Parish, 1973) this is equivalent to 145,000 tablets in 2,320 prescriptions issued by each general-practitioner principal. Forty-one per cent of the drugs were hypnotics, 38 per cent tranquillisers, 15 per cent antidepressants, and six per cent stimulants and appetite suppressants.

TABLE 4

PSYCHOTROPIC DRUGS: THE NUMBER AND SEX OF PATIENTS AND PERCENTAGE (IN ITALICS) OF THE POPULATION PRESCRIBED THEM IN AGE GROUPS

Age	*0–14*	*15–24*	*25–34*	*35–44*
Male	5 *1·7*	5 *3·6*	5 *3·3*	13 *7·8*
Female	8 *2·8*	9 *6·0*	22 *13·2*	25 *15·0*
Total	13 *2·3*	14 *4·5*	27 *8·5*	38 *11·4*
Age	*45–54*	*55–64*	*65 and over*	*All ages*
Male	22 *17·6*	8 *6·8*	27 *24·6*	86 *7·6*
Female	32 *21·6*	29 *24·8*	37 *25·3*	162 *13·7*
Total	54 *19·6*	37 *15·8*	64 *25·0*	248 *10·7*

Details missing: age of one male.

The patients treated

The population treated

There was a steady rise with age in the proportion of the population prescribed psychotropic drugs except in the case of males in the decade 55–64. Twice as many females as males were treated.

In November 1971, towards the end of the year of this survey, *The prescribing of psychotropic drugs in general practice* by Parish was published as a supplement to this *Journal.* In this he surveyed national prescribing and also reported in detail on the prescribing of psychotropic drugs by 48 doctors to a population of 133,081. In table 5 my practice is compared with the average of these doctors.

TABLE 5

THE PERCENTAGE OF THE SURVEY POPULATION RECEIVING PSYCHOTROPIC DRUG THERAPY BY THERAPEUTIC SUBGROUPS AND SEX COMPARED WITH THE PARISH SURVEY (1971)

	Female	*Male*	*Total*
Barbiturate hypnotics	*4·2 (2·43)*	*2·4 (1·08)*	*3·3 (1·76)*
Non-barbiturate hypnotics	*0·8 (2·60)*	*0·6 (1·46)*	*0·7 (2·03)*
Tranquillisers	*9·1 (13·60)*	*5·0 (6·65)*	*7·2 (10·13)*
Stimulant and appetite supressants	*0 (1·78)*	*0 (0·26)*	*0 (1·02)*
Antidepressants	*5·6 (3·96)*	*2·5 (1·67)*	*4·1 (2·82)*
Population treated	*13·7 (17·1)*	*7·6 (8·00)*	*10·7 (12·60)*

Parish survey figures are shown in brackets.
Included in this survey but excluded in the Parish survey: phenobarbitone prescribed for epilepsy; 'Stemetil' prescribed for vertigo; the 0–15 age group.

No appetite suppressants or amphetamine preparations were prescribed during the year. The 3·3 per cent of the population prescribed barbiturate hypnotics consisted of 76 patients and 36 of these were given phenobarbitone. The ratio of the population prescribed antidepressants to the population prescribed other classes of psychotropic drugs was 1 : 2·7 in this survey and 1 : 5·3 in the Parish survey.

TABLE 6

ORGANIC DISEASE: THE NUMBER AND PERCENTAGE OF THE POPULATION PRESCRIBED PSYCHOTROPIC DRUGS IN THE AGE GROUPS

Age	*0–14*		*15–24*		*25–34*		*35–44*		*45–54*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
C.N.S.	1	0	0	0	0	2	0	2	2	0
Other	1	3	1	1	1	1	2	2	1	2
Total	2	3	1	1	1	3	2	4	3	2
% population	*0·7*	*1·0*	*0·6*	*0·7*	*0·7*	*1·8*	*1·2*	*2·4*	*2·4*	*1·4*

Age	*55–64*		*65 and over*		*All ages*		*Total*	*% population*
	M	*F*	*M*	*F*	*M*	*F*		
C.N.S.	0	3	1	7	4	14	18	*0·8*
Others	5	1	4	3	15	13	28	*1·2*
Total	5	4	5	10	19	27	46	
% population	*4·3*	*3·4*	*4·5*	*6·9*	*1·9*	*2·3*	*2·0*	

Organic disease

The patients with organic disease who were given psychotropic drugs are divided into two groups: disorders of the central nervous system and other systems. The former category includes epilepsy (five cases), vertigo (eight), mental defect (two) and dementia (two). The latter comprises those patients without any apparent psychiatric disorder, but with somatic disease, which it was thought psychotropic drugs might benefit, including dyspepsia (four), vomiting (four), neoplasia (three), nocturnal eneuresis (three), thyrotoxicosis (one), and pre-eclamptic toxaemia (one). There was little difference between the proportions of male and female populations treated.

Anxiety

In the males there was a steady rise in the incidence of ' anxiety ' from the age of 25 up to a maximum in the decade 45–54 followed by a sharp fall in the following decade and a further steep rise after the age of 65.

TABLE 7

ANXIETY: NUMBER OF PATIENTS AND PERCENTAGE (IN BRACKETS) OF THE POPULATION PRESCRIBED PSYCHOTROPIC DRUGS IN AGE GROUPS

Age	*0–14*		*15–24*		*25–34*		*35–44*	
Male	0	*0*	0	*0*	2	*1·3*	6	*3·6*
Female	2	*0·7*	2	*1·3*	15	*9·0*	12	*7·2*
Total	2	*0·3*	2	*0·6*	17	*5·3*	18	*5·4*
Age	*45–54*		*55–64*		*65 and over*		*All ages*	
Male	11	*8·7*	1	*0·9*	7	*6·4*	27	*2·4*
Female	19	*12·8*	13	*11·1*	6	*4·1*	69	*5·8*
Total	30	*10·9*	14	*6·0*	13	*5·1*	96	*4·2*

TABLE 8

ANXIETY: THE DURATION OF TREATMENT IN WEEKS; THE NUMBER OF CONSULTATIONS IN RELATION TO DURATION; THE AVERAGE INTERVAL BETWEEN CONSULTATIONS IN WEEKS

Weeks	*0–4*	*5–9*	*10–19*	*20–29*	*30–39*	*40–49*	*50–59*	*All*
Number of episodes	62 (1)	14 (1)	5 (11)	3	2	3 (1)	10 (10)	100
Total duration	151	89	57	89	71	129	520	110-
Number of consultations	82	40	15	28	23	33	103	324
Average interval between consultations in weeks	1·8	2·2	3·8	3·2	3·1	3·9	5·0	3·4

The figures in brackets indicate the number of patients whose treatment extended before or after the survey year. Details missing: reason for treatment (one case); number of consultations (two cases).

Anxiety, tension, or grief are normal reactions to the ' slings and arrows of outrageous fortune '. Patients now ask for drugs to mask their unpleasantness and the response of the doctor depends on his personal philosophy and willingness to withstand or comply with his patients' wishes. The tables recorded above are meaningless without a description of my personal response to my patients.

I run my practice with a low attendance rate (2·9 attendances per patient per year), so that there is time to allow patients to talk and for me to listen and seek to influence them. The appointments are booked to allow ten minutes for each consultation, but this is not rigidly adhered to, so that there is usually no obstacle to a first attendance lasting half an hour if appropriate.

The patients are told that tranquillisers are not curative, but equivalent to alcohol in that they temporarily calm the reaction to stress. It is pointed out that to suggest a double whisky three times a day would seem wrong and that similar prescribing of tranquillisers would be no different except in the sense of appearing spuriously respectable: they would both be very pleasant to take and tempting to continue as an addiction. Patients are encouraged therefore not to take tranquillisers regularly, but only when they feel they cannot cope with current stress.

In 56 of the cases treated for anxiety only one prescription was given and in 42 of these the patient was only seen once. It may well be argued that none of these patients required treatment at all, but there is a cultural expectation of some sort of medication which I often find difficult to withstand; this is weak, but the single prescription is a compromise. One of these single prescription patients was newly registered and had been taking 'Librium' continuously for eight years, but accepted without rancour that it was therefore time she stopped and when next seen a year later was grateful.

However, there are some patients who have a long continued feeling of anxiety which is not markedly reactive to the environment and seems analagous to endogenous depression. These patients made up the majority of the few treated with long-term tranquillisers.

Requests for tranquillisers before driving tests and examinations have always been refused without exception and consequently are now rare.

Four patients were suffering from grief and these were all encouraged to weep and given only a few tablets. It is hard to believe that this uniquely human complex of respiratory spasm, phonation, and lachrymation, an attribute of all ages, does not have some valuable function in the survival of the species.

All these patients were prescribed 'Librium', 'Valium', 'Amytal' or phenobarbitone. The major tranquillisers were all prescribed for those with organic disease or psychoses.

Depression

As with anxiety there was a fall in the male incidence in the 55–64 decade and twice as many females were treated.

There was a striking difference between the duration of treatment of patients treated for anxiety and depression (tables 8 and 10). Whereas in the case of anxiety 62 patients were treated for periods shorter than five weeks and 37 for longer, in the case of depression the corresponding figures were 16 and 67.

Depressed patients are always seen at frequent intervals in the early stages. Those who are very distressed may be seen every few days until they improve. Moderate or mild cases are warned about side-effects and told that they must persist, as they will probably find no improvement for a fortnight. Mild cases are usually given 'Tryptizol' 75 mg and bad ones 150 mg daily with most of this at night to render the side-effects less obtrusive and to help sleep. The frail or very small are given 10 mg tablets instead.

The 12 patients treated for a short period and then stopped with doubt about the diagnosis are disconcerting. I think that when in doubt it would be better to have several talking sessions perhaps trying a tranquilliser to allow time for the diagnosis to clarify or for the patient to recover spontaneously.

The patients nearly all do well. The dose of 'Trpytizol' is increased until the patient

TABLE 9

DEPRESSION: NUMBER OF PATIENTS AND PERCENTAGES (IN ITALICS) OF THE POPULATION PRESCRIBED ANTIDEPRESSANT DRUGS IN AGE GROUPS

Age	*0–14*	*15–24*	*25–39*	*35–44*
Male	0 *0·*	1 *0·6*	2 *1·3*	4 *2·4*
Female	1 *0·4*	3 *2·0*	9 *6·0*	8 *4·8*
Total	1 *0·2*	4 *1·3*	11 *3·5*	12 *3·6*
Age	*45–54*	*55–64*	*65 and over*	*All ages*
Male	9 *7·1*	1 *0·9*	8 *7·3*	25 *2·2*
Female	12 *8·1*	9 *7·7*	13 *8·9*	55 *4·7*
Total	21 *7·6*	10 *4·3*	21 *8·2*	80 *3·5*

TABLE 10

DEPRESSION: THE DURATION OF TREATMENT IN WEEKS; THE NUMBER OF CONSULTATIONS IN RELATION TO DURATION; THE AVERAGE INTERVAL BETWEEN CONSULTATIONS IN WEEKS

Weeks	*0–4*	*5–9*	*10–19*	*20–29*
Number of episodes	16 (4)	9 (8)	16 (7)	13 (5)
Total duration in weeks	40	68	200	305
Number of consultations	34	41	80	104
Average interval between consultations in weeks	1·2	1·7	2·5	2·9
Weeks	*30–39*	*40–49*	*50–65*	*All ages*
Number of episodes	8 (4)	7 (5)	14 (14)	86
Total duration in weeks	268	301	726	1908
Number of consultations	63	81	168	571
Average interval between consultations in weeks	4·3	3·7	4·3	3·3

Number of episodes: the figures in brackets refer to the number of patients whose treatment extended before or after the survey year.
Details missing: duration of treatment (three cases).

and the spouse feel recovery is complete and then after a variable period is slowly reduced, usually in steps of 25 mg each month. If there is any relapse this process is reversed. Some patients require a small dose apparently indefinitely, but I have never met any problems from addiction.

Six patients were treated with monoamine oxidase inhibitors as they had failed to respond to a tricyclic drug.

Two patients were being treated as outpatients with lithium, but I was not responsible for prescribing or supervising it and therefore have not included this drug in my paper.

Johnson (1973) is critical of the treatment of depression in general practice both for the frequency of consultations and dosage of drugs, but I can see no reason why this condition should not be adequately handled by the patients' own doctor in the great majority of cases.

Insomnia

There was the same fall in the male incidence in the decade 55–64 as in the previous two conditions. In this case there was no sex difference in the prescribing.

TABLE 11

INSOMNIA: NUMBER OF PATIENTS AND PERCENTAGE (IN ITALICS) OF THE POPULATION PRESCRIBED HYPNOTICS IN AGE GROUPS

Age	*0–14*	*15–24*	*25–29*	*35–44*
Male	0	2 *1·2*	0	0
Female	0	0	2 *1·2*	1 *0·6*
Total	0	2 *0·6*	2 *0·6*	1 *0·3*
Age	*45–54*	*55–64*	*65 and over*	*All ages*
Male	3 *2·4*	1 *0·9*	7 *6·4*	14 *1·2*
Female	1 *0·7*	2 *1·7*	8 *5·5*	14 *1·3*
Total	4 *1·5*	3 *1·3*	15 *5·9*	28 *1·2*

Detail missing: age of one male.

TABLE 12

INSOMNIA: THE DURATION OF TREATMENT IN WEEKS; THE NUMBER OF CONSULTATIONS IN RELATION TO DURATION; THE AVERAGE INTERVAL BETWEEN ATTENDANCES

Weeks	*0–4*	*5–9*	*10–19*	*20–29*
Number of episodes	11	4	0	1
Total duration in weeks	30	32	0	20
Number of consultations	10	6	0	3
Average interval between consultations	3·3	5·3	0	6·6
Weeks	*30–39*	*40–49*	*50–52*	*All*
Number of episodes	1	2 (1)	10 (10)	29
Total duration in weeks	34	97	520	733
Number of consultations	?	23	57	99
Average interval between consultations	?	4·2	9·1	7·4

The figures in brackets refer to the number of patients whose treatment extended before or after the survey year. Detail missing: number of consultations (one case).

Most patients were treated for either short periods or continuously. Of the ten patients (0·4 per cent of the population) given hypnotics for insomnia for more than a year, nine were over 65 years old, including five over 80 years. It is almost impossible to wean these old folk from their sleeping tablets, but it is important not to recruit more to take their place.

I have been greatly influenced in my handling of insomnia by my experience of one dear old lady who was on my regular visiting list for many years. As she complained of sleeping badly she was prescribed ' Sodium Amytal ' 200 mg but, despite this, she continued to complain at every visit even after I was foolish enough to double the dose. When she was over 90 she fell sustaining a fractured hip necessitating a spell in hospital for pinning. She was discharged home without any hypnotic and until her death some years later she was happy to assert that she slept very well.

When asked for sleeping tablets some are refused and others are usually given 20 or 30 tablets with instructions to take two for two nights then one for another couple of nights and to keep the rest on the shelf with the firm statement that the prescription will not be repeated.

This policy consistently maintained over a number of years has led to such requests now being extremely rare, for patients discuss their doctor's foibles and adapt to them without conflict. Contrastingly, two prospective patients wishing to register and renew their hypnotic stocks withdrew their applications on having my policy made clear.

Some patients requesting hypnotics are depressed and are treated appropriately. Others are suffering from organic or psychiatric illness with sleep disturbance. To the ten patients mentioned above must be added three with somatic disease, four with anxiety, and one with depression making a total of 18 patients (0·8 per cent) of the population to whom hypnotics were prescribed for more than a year.

Johnson and Clift (1968) found that in five practices with a total of 29,600 patients, 1·4 per cent of them had been prescribed long-term hypnotics.

TABLE 13
PSYCHOSIS: DIAGNOSIS; DURATION OF TREATMENT; NUMBER OF CONSULTATIONS; NUMBER OF PRESCRIPTIONS

Sex	*Age*	*Diagnosis*	*Duration of treatment in weeks*	*Number of consultations*	*Number of prescriptions*
F	55	Mania	8	2	3
		Mania	7	4	2
F	54	Schizophrenia	52–	6	5
F	57	Schizophrenia	44–	12	8
M	19	Schizophrenia	43–	6	9
All			154	30	27

TABLE 14
BEHAVIOUR: DIAGNOSIS; DURATION OF TREATMENT; NUMBER OF CONSULTATIONS; NUMBER OF PRESCRIPTIONS

Sex	*Age*	*Diagnosis*	*Duration of treatment in weeks*	*Number of attendances*	*Number of prescriptions*
M	1	Night crying	3	2	1
M	42	Aggression	15	9	4
F	24	Hypo-chondriasis	24	2	2
F	1	Irritability and failure to thrive	4	1	1
F	14	Tic	2	2	2
		All	48	16	10

Psychosis

The effect of drugs on these conditions is impressive, but the problem with schizophrenia is to persuade the patient to continue treatment. There were a number of other known cases in the practice who were not taking treatment during the survey year.

Behaviour

Most children whose mothers are complaining of night crying are treated without medication by allowing the child to scream, if necessary all night, without any attention preferably after a single visit by the father with a hard slap. Remarkably, this Pavlovian deconditioning usually works after one night only, but the neighbours have to be warned with ' doctors's orders ' given as the scapegoat, for a strong determined child will scream for hours before being overcome by exhaustion.

Parents today are frightened to follow their own instincts in bringing up their children. They have half-digested half-baked articles and television talks and in consequence fear that to punish or thwart them will in some way do them irreparable harm by ' repressing ' them. Their forbears were spared these inhibitions and only had their love and common sense to guide them; yet formerly the nation prospered and became more civilised. As one old lady told me " You see doctor we brought up our children, but now the children bring up their parents." Undoubtedly the household anarchy which ensues is a potent source of maternal stress and it is likely to be transferred to teachers and society later. The problems of childhood are not dealt with by drugs, but by advice and encouragement based on this primitive approach.

TABLE 15
PATIENTS REFERRED TO HOSPITAL DURING THE SURVEY YEAR

	Sex	*Age*	*Diagnosis*
Inpatient referrals	F	25 yrs	Depression
	M	19 yrs	Schizophrenia after a domiciliary consultation
Outpatient referrals	F	14 yrs	Depression
	F	36 yrs	Depression
	M	42 yrs	Depression
	F	47 yrs	Manic depression
	F	55 yrs	Manic depression
	F	81 yrs	Senile dementia

Hospital referral

This was an exceptionally high number of referrals. During the four years 1971–1974 in which comprehensive records of hospital referral have been kept there have been six inpatient referrals (excluding four overdose admissions to casualty departments) and ten outpatient referrals including those listed above. The total hospital referral rate for the survey year was 3·5 per 1,000 patients in the practice compared with 1·7 for the four-year period.

The Royal College of General Practitioners (1973), *Present state and future needs of general practice* gives a combined annual psychiatric inpatient (ten) and outpatient (12) referral of 22 per 2,500 patients (8·8/1000).

Overdose

During the survey year there was one overdose: a patient took a large number of iron tablets while on weekend leave from hospital where she was being treated for depression.

I have been in this practice since 1951 and until 1966 there were no cases of self-poisoning, but thereafter my patients followed the rapidly increasing national fashion so that by 1970 there had been six. Four of these had been attending me and three of them took the drugs I had given them. By this time I was dispensing large quantities of psychotropic drugs and, being alarmed at the hazard, introduced the following counter measures:

TABLE 16
OVERDOSES: DATE; SEX AND AGE OF PATIENT; MEDICAL ATTENTION AT THE TIME; SOURCE OF DRUGS; AND CAUSE

Date	*Sex*	*Age*	*Drug*	*Medical attendance*	*Source of drug*	*Cause of overdose*
1966	M	37	'Amytal'	General practitioner	General practitioner	Desertion of wife
1968	F	53	'Amytal'	—	Stolen	Upset at reprimand of employer
1969*	F	23	'Tryptizol' and 'Valium'	General practitioner	General practitioner	Depression and marital unhappiness
1970	F	48	'Tryptizol'	General practitioner	General practitioner	Depression
1970	M	49	'Aspirin'	General practitioner	Bought	Torn between lover and family
1970**	M	21	Not known	—	Black market	Unhappy homo-sexual
1971*	F	24	Ferrous sulphate	Hospital inpatient	Hospital	Depression with matrial unhappiness
1972	F	54	'Avomine'	—	Bought for travel sickness	Indecision re deser-tion to lover
1972	F	18	'Aspirin' and 'Avomine'	Psychiatrist	Bought and general practitioner	To persuade psychia-trist to change his mind re abortion
1974**	M	25	Not known	—	Black market	Unhappy homo-sexual
1973	F	42	'Aspirin' and alcohol	—	Bought	Domestic row. Death

*and **indicate two patients who each took two overdoses.

(1) All patients receiving psychotropic drugs (or any other regular medication) have a card inserted in their notes.

This card enables the doctor to see at a glance what medication the patient is supposed to be taking and how many tablets have been prescribed on what date. The timing of the doses is indicated: ' 1, 1, 4 ' means one mane, one midday and four nocte. This is also useful to partners who may have to see a strange patient at the weekend.

Patients with unavoidably complicated drug schedules are given a duplicate.

(2) The patient is given another appointment and the exact number of tablets to last until then. Thus a patient to be seen in a fortnight and prescribed ' Tryptizol ' 25 mg 1, 0, 3 would be given 56 tablets.

(3) Patients are expected to bring their drug bottles with them and are encouraged to believe that the motive is to save bottles. In fact any tablets remaining in the bottle are subtracted from the number of new tablets given in order to curtail their chances of acquiring a hoard. It is also a means of checking their reliability in drug taking.

(4) If there is a doubt about a depressive who does not convincingly deny suicidal thoughts, the drugs are given to the spouse who is instructed to leave only the day's dose with the patient.

(5) Apart from a few of the old folk taking hypnotics regularly, psychotropic drugs are only prescribed when the patient attends me personally.

Since starting these measures, i.e. 1971–74, there have been five further overdoses, none of them with psychotropic drugs and none of the patients concerned were attending me. One of these cases was fatal: a husband and wife had a heavy drinking night at the pub and then returned home to a customary domestic row in the course of which the wife took a large number of aspirins and died; the panicking husband did not send for the doctor until the following morning.

For overdoses attended a Senoran's evacuator is used with a large bore stomach tube until clear washings are obtained. The patient is held in the prone position with the head held over the edge of the bed or couch with the pressed help of a neighbour or relative. This procedure is usually completed by the time of arrival of the ambulance and I hope, speeds the recovery of the patient. No cases of pneumonia have ensued.

The annual overdose rate in the practice both for the five years 1966–70 and for the four years 1971–74 was 0·5/1000. It is disappointing that the measures listed above have achieved no improvement, but it may well be that they have prevented a worsening in a period during which a large number of patients were being treated for depression.

The annual suicide attempt rate given in Royal College of General Practitioners, *Present state and future needs of general practice* (1973) is 1·2/1000.

TABLE 17
ATTENTION GIVEN TO PATIENTS TREATED FOR PSYCHIATRIC CONDITIONS

	Anxiety	*Depression*	*Insomnia*	*Psychosis*	*Behaviour*	*Total*
Number of patients	96	80	28	4	5	213
Number with obtrusive organic disease	21	10	15	1	1	48
Number of episodes treated	100	86	29	5	5	225
Number of consultations	324	567	99	30	16	1036
Number of prescriptions	208	411	76	27	10	732
Total duration of tıeatment (weeks)	1106	1908	733	154	48	3949

Workload

In 1971 the total number of consultations in the practice amounted to 6,676 so that the 1,036 consultations held with the 213 patients receiving psychotropic drugs for psychiatric conditions accounted for 15 per cent of the whole. This implies that these patients were seen 1·7 times as often as the rest of the practice. These consultations with psychiatric patients included those for any organic conditions occurring during their courses of treatment. The number of consultations is a poor indicator of the time spent on these patients for, in general, psychiatric consultations last longer than those for organic disease. In addition there were those with psychiatric problems who were treated by discussion but without psychotropic drugs and therefore excluded from this survey.

Discussion

The prescribing of large quantities of barbiturates, tranquillisers, and drugs with which I was unfamiliar was unsatisfactory.

Relative to the surveys quoted, the ratio of attendances to prescriptions and the proportion of patients treated with antidepressants was high whereas the total of psychotropic prescriptions and tablets, the number of patients given long-term hypnotics, and the annual hospital referral, and overdose rates were low.

The patients treated for anxiety pose the most questions. There are the few with chronic anxiety; perhaps ideally these should be treated with psychoanalysis and not the discussion and tranquillisers or β-adrenergic blockers, which is all I am able to offer.

The others are suffering from life itself. Is society now too condoning of those who react to it with ' nerves '? In war it is necessary to decry cowardice and extol courage or no battles would be won and maybe a return to former attitudes with less complaisance is desirable. Should this be a medical matter at all? I am sure that the most potent remedy here is the patient talking out the problem with a sympathetic but independent minded listener, ideally a relative or friend. The allegedly " high standard of living " in our society is often high in material good, but low in enduring human relationships at work and at home. Since few are ' loners ', the doctor has to be a second best substitute in those areas such as the new housing estate in my village where each household with its nuclear family is as solitary as a Pacific atoll. The potential demand for the doctor in this role is limitless.

The wealthy in the U.S.A. have their psychologists who have been called prostitute friends; the limit there is cost. The general practitioner here is cost free so that he himself must consciously maintain a limit and see that the patient does not become addicted. It is easier to prescribe a tranquilliser, but this too is pleasant to the patient who may be loath to give it up. It would be better never to start and in some cases I try to revert to Mist. gentian et pot. brom. which is unpleasant and inconvenient to take.

In contrast I believe the antidepressants are pharmacologically curative. The doctor-patient relationship may marginally ease suffering by offering hope and sympathy while waiting for the drug to work, but it is the pills which do the good. The main purpose of these consultations is to ensure that the patient persists with medication despite the side-effects and to detect a suicidal danger. Once a patient has been in the slough named despond and comes out with the help of tablets he no longer needs persuasion and at this stage counselling may be helpful. Many patients and their spouses aver that life has become better than for many years; such cases are gratifying to treat and cause no qualms. It is normal to be happy and normal to be sad and some patients complain of the latter as depression even though it may be an appropriate mood response to life. Some are probably suffering from the " entropy of feeling " described by Konrad Lorenz (1974) as resulting from the absence of danger and discomfort currently usual in most of our still affluent kingdom. It is these whom I find difficult but, fortunately, if a patient is treated needlessly the absence of benefit combined with the unpleasantness of the side-effects will soon ensure that the drug is stopped and no great harm is done.

In conclusion, I think that the increase in the number of " functional " patients has been due to a number of factors: an increase in population, mainly due to an influx of strangers in nuclear families; an increase in psychiatric morbidity perhaps due to the impersonality, physical ease, and complexities of mobile modern life; an increase in my interest; the ability to treat depression. Given these changes and in the light of the findings recorded above, I see no reason for a fundamental change in my present practice other than achieving a substantial reduction in the prescribing of barbiturates and a less ready use of minor tranquillisers.

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