BRITISH MEDICAL JOURNAL

SATURDAY 6 OCTOBER 1984

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6449 BRITISH MEDICAL JOURNAL 1984 VOLUME 289 853-936
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0007-1447
ASTM CODEN: BMJOAE 289 (6449) 853-936 (1984)

CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Unrecognised psychiatric illness in medical patients

SIR,—Sir John Nabarro (15 September, p 635) asks three questions. How common is psychiatric illness in medical patients? How important is it that it should be recognised and documented? If it is important what can be done to ensure more frequent recognition?

"How common is psychiatric illness in medical patients" is similar to "How long is a piece of string?" It all depends on the psychiatric interest and awareness of the doctor, and the greater these are the more complete the doctor and the more the benefit reaped by the patient.

"How important is it that it should be recognised and documented?" Let me illustrate this by some examples from my general practice. Firstly, the 60 year old woman with a 10 year history of progressive loss of vision due to macular degeneration who when asked what the illness meant to her answered that it was a punishment from God. She described a family quarrel some years earlier with a sister whom she then had ignored—so much so that she averted her gaze whenever she saw her. The loss of vision was, indeed, retribution. The opportunity to talk about this was grasped eagerly by the patient and led to a considerable and sustained elevation of mood.

Next, the sudden onset of severe headache in a 45 year old woman which lasted unremittingly for a week until the disclosure in the consultation that it was the seventh anniversary of her husband's death. This had been particularly traumatic since she had wakened one morning to find him dead beside her. The headache rapidly disappeared without treatment.

Lastly, the depressed 66 year old man who had discontinued his monoamine oxidase inhibitors during my absence from the practice, developed abdominal pain, and been subjected to an unnecessary cholecystectomy. His pain returned until he restarted his antidepressive treatment.

"If it is important what can be done to ensure more frequent recognition?" Hospital patients form the apex of the pyramid whose base is in general practice.

The ability to recognise the psychological or psychiatric component of illness is a skill to be taught and learnt just as much as the examination of an abdomen or the interpretation of an electrocardiogram. One way of learning is by attending general practitioner seminars or Balint groups headed by a skilled tutor. About 1% of general practitioners do this.

The general practitioner has the unique opportunity of not only knowing his patient but also his family, his home, and his background. This enables psychological problems to be recognised earlier and to be helped. Patients waste medical time in laboratory investigations and in hospitals often because the initial referral is made by a practitioner whose awareness of the psychological problems of the patient is minimal. This is the crux of the matter.

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SIR,—Sir John Nabarro's recent leading article (15 September, p 635) is a timely reminder about the problem of hidden emotional illness among hospital patients. As far back as 1959 Querido drew attention to the impact of social and mental factors on the outcome of hospital treatment.[1] But what of patients who are not in hospital wards but are cared for in the community by family doctors? As Goldberg and Huxley pointed out in their study of the pathways of psychiatric care, most of the long-standing mood disorders of patients will be known to their family doctor, but many associated somatic complaints pass through his hands unwittingly.[2] Unrecognised emotional illness is as common in the community as in hospitals, and the opportunities for detecting it great, if not greater. Goldberg and Huxley were able to identify 10 aspects of a family doctor's interview style that related to his accuracy as a case detector for emotional illness and that, most importantly, could be modified by training. By enhancing the general practitioner's skills in recognising psychiatric illness, and by improving communication between general practice and hospital, better care could be achieved. It is in the precise and economical use of time that the doctor's skill must be developed.

Formal psychiatric interviewing is inappropriate in a six or 10 minute consultation. There are problems posed by age and intelligence, and by a patient's notion of what is appropriate to present to a doctor. As important is the patient who reveals emotional difficulties only through physical symptoms or through the intermediary of a child's disorder.

It may be important that in the study quoted by Sir John Nabarro medical students had most success in detecting emotional problems. I suspect that this is not just a function of the time at their disposal but due to an ability to