much space the computer must reserve for each patient. Each new item, as it is collected, is simply added to the file at the next vacant position and the chain pointer of the last item is set to this location.

To sum up, my own view is that we do not know if our familiar faces are really very familiar, that it is important that we find out, but that the problems of identification are indeed formidable.

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Familiar Faces – The Constant Attender

The constant attender in Ireland bears the same expression, compounded in equal parts of complaint and self-satisfaction, as his English brother (or sister). 'People is people is people': and while groups acquire group characteristics which encourage us to make generalizations about the young, the Irish, the Catholic or the Welsh, such generalizations are particularly useless in the one-to-one situation of the consultation. It will be no surprise, therefore, if I, being Irish, immediately proceed to try to identify groups of constant attenders and to generalize about their characteristics.

The patients I wish to talk about are those whose names in an appointment list produce anticipatory feelings of rage at the unfairness of our lot, hopelessness at our inadequacy and some slight twinges of guilt. This is because they do not obey the rules of the game which we have been expensively trained to play. These rules are based on the premise that the patient is ill and that he or she comes to the doctor seeking a cure. It follows that we are likely to be confused if the patient is not ill according to our rules or if the reason for his attendance is not to seek a cure.

From the doctor's point of view the ideal patient presents with symptoms which direct a search for objective confirmatory signs which lead to a sure diagnosis and curative therapy. We are all familiar with the relief and joy with which we welcome an acute tonsillitis in the middle of a trying surgery. Our greatest joy and certainly the main delight of most of our physician colleagues is an obscure disease which conforms to the rules but whose successful diagnosis taxes our cerebral cortex without disturbing our emotional equanimity. A proportion of our familiar faces who suffer from chronic and incurable diseases do conform to the rules and, perhaps surprisingly, our inability to cure seems to distress us, and sometimes them, surprisingly little. They do not, however, disturb us emotionally and I do not propose to talk about them further.

The assumption that all our patients seek a cure is dangerous because it can be misleading. Ill-health, excluding mental ill-health, is morally respectable in our society. There are still relatively few situations when 'I do not want' or 'I do not wish to... ' is acceptable to employers, schoolmasters, parents, spouses or colleagues, and even young children are quick to appreciate that 'I have a pain and therefore cannot' provides an escape route from unpleasant situations. The State, parents and spouses constantly demand of us that we, as doctors, should arbitrate between sickness and health, between disease and blood-mindedness. Unfortunately not only are such decisions impossible but the request to make the decision is usually, initially at any rate, disguised as a request to cure symptoms.

The situation is relatively simple in the case of the State where necessary proof is the issue of a piece of paper and none of us can deny that we have secured a peaceful modus vivendi with many constant attenders by the use of the pen. We acknowledge in our hearts that the organic disease label on the certificate is inadequate justification for permission to avoid work in perpetuity but placate our consciences by reminding ourselves of the subjectivity of pain and the 'inadequacy' of certain personalities.

Unfortunately a certificate vouching for ill-health which might be shown around the family circle is not an acceptable solution for the housewife and many women must attend the doctor in order to establish the fact of illness. They require in lieu of a certificate a diagnostic label and are in a weak position unless the therapeutic regimen involves the swallowing of some tablet or potion. Thus doctor and patient find themselves engaged in a game in which they do not share the same objective. As Balint et al. (1970) have shown, many patients happily obtaining repeat prescriptions with the minimum doctor-patient contact very much resent any disturbance of this stable and, for them, satisfactory situation. Of course, not all patients who are manipulating their environment on the plea of ill health succeed in maintaining a stable state. Their failure to do so is likely to result in an attack upon the doctor: 'My husband says that
something must be done about my back.' A situation which inevitably leads to X-rays of the spine and a visit to an unsuspecting orthopedic surgeon who in desperation adds to the burdens of an overloaded physiotherapy department. Occasionally driven into a corner, an abrupt change of tactic, a switch from 'my back' to 'my stomach' with a sideswipe at 'the pills' which she has been taking allows the situation to continue happily for another prolonged term.

Somewhat different from these patients are those who live in genuine fear and for whom living is fraught with danger. Wet feet inevitably lead to pneumonia; an enlarged gland means leukemia; diarrhoea, lethal gastroenteritis; a sniffle, influenza; a sebaceous cyst, cancer. Fortunately, particularly in a long-continued illness, where confidence is based on reassurance; but unfortunately their need for reassurance diminishes but little and so they soon become familiar faces. It is sad to watch the skill and determination with which these patients instil the same disastrous attitudes into their unfortunate offspring and to see how often Granny succeeds in perpetuating her handiwork.

There is a group of really horrible people who use the doctor as an emotional punchbag. These unfortunate people find themselves alone in middle life largely because of their behaviour towards others over the years, and as a result they tend to become alienated, in whole or in part, from their families. However, they retain the behavioural characteristics which, over the years, have succeeded in leaving them out on a limb and bear a grudge against the world as a whole for having treated them so hardly. The doctor remains one of the few remaining outlets for their emotions; he is used, as I have suggested, as a punchbag on which they can rid themselves of some of their pent-up resentments. One of the saddest things about organized religion is that religious groups tend to be overloaded with these people who, within the group, find another captive audience.

I do not see the problem of the constant attender as being one of disease, either mental or physical. At which point you may well accuse me of indulging in an exercise in semantics. My statement could be rephrased by saying that the problems of most of our constant attenders arise from attitudes which, in their turn, have led to undesirable patterns of behaviour, rather than from disease. I think there is a valid distinction to be made between the neuroses, using the word in a wide sense, and the organic syndromes of mental illness. Manic depressive psychosis, schizophrenia and the organic dementias may all be characterized by abnormal attitudes or beliefs.

But, in contrast to the neuroses, therapy with drugs in the case of manic depressive psychosis and schizophrenia is relatively effective. In neurosis the faulty attitude would seem to be the primary disorder rather than a resulting symptom, and it is as a result of these faulty attitudes that our patients have difficulty in coping with life.

We must alas accept that what I have referred to as attitudes are the hardest things to change. Their resistance to change would seem to be the major bar in preventing the human race from achieving some form of Utopia. The appeal to reason would appear totally ineffective when faced with an alcoholic, a drug addict or our constant attenders. No more effective is the use of drugs. Is there an alternative? Can we ever hope to change people's attitudes? It is certain that change cannot be imposed but I think it just possible that we can assist patients to change themselves.

As doctors we have received a lengthy training in which the main method of teaching has been Jesuitical. By this I mean that we have been instructed with varying degrees of efficiency and sophistication in the facts. Our teachers have played the god-like role of being the fountainheads of knowledge who were imparting their wisdom to us the recipients. We are also familiar to some extent with the Socratic technique whereby the teacher by use of question and answer guides the pupil to a knowledge of the correct answer. It is therefore inevitable when advising (or teaching) our patients that these are the techniques we use. Most of us have become reasonably skilled in translating medical terminology into everyday language but this represents our particular expertise, not a new method. Even our attempts at psychotherapy tend to end with a homily of advice delivered didactically, occasionally reinforced by Socratic question and answer.

As a result of attending the teachers' course run by the Department of General Practice in the University of Manchester I have been made aware of the technique of 'non-directive behavioural counselling'. This differs from Jesuitical or Socratic techniques in that the counsellor, without emotional involvement, aims to create a situation in which the counsellor, or patient, can examine and define his problems. He can then be encouraged to examine possible solutions and to accept and test that which he feels most likely to succeed. The technique can only be successful if all decision-making is undertaken by the patient – it rests on the assumption that advice is useless unless the patient himself decides to act upon it.

The technique is not an easy one to learn, particularly as it demands from the counsellor a role which to us as doctors is unfamiliar. It is
extraordinarily difficult for doctors to ask questions without providing answers. My experience with counselling is as yet very limited and I am sure unskilful. It has certainly worked no miracles and it needs time. It may have helped me more than it has helped my patients in that it has given me a positive therapeutic role and increased my understanding of these unhappy people. Their visits are a little more of a challenge and a little less of an ordeal. I hope that I have helped them to understand themselves a little better; I know that I have acquired a greater tolerance to their demands.

REFERENCE

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Clinical and Social Aspects of Chronic Neurosis

Although it would be wrong to equate frequent surgery attendance with neurosis, a number of surveys have demonstrated that patients with chronic or recurrent psychiatric symptoms contribute more than their share to the general practitioner's work-load (Shepherd et al. 1966, Cooper et al. 1969). As they also maintain higher-than-average rates both for specialist referral and for hospital admission (Cooper et al. 1969, Harvey-Smith & Cooper 1970), such patients constitute a heavy burden on the medical services. Neither is there any evidence that the current large-scale prescribing of psychotropic drugs by general practitioners is helping to reduce this demand for medical care: on the contrary, the number of spells of certified incapacity ascribed to psychiatric illness continues to rise steadily (Department of Health and Social Security 1970).

These considerations underline the need for systematic investigation of the problems of chronic neurotic illness encountered in general practice. Some years ago, a descriptive study of 100 chronic psychiatric patients in a general practice sample found associated physical disease in half the cases and conspicuous social difficulties in one-third (Cooper 1965). Both these leads have since been followed up by the General Practice Research Unit at the Institute of Psychiatry: first, a controlled study of a middle-aged population sample confirmed the association between physical and psychiatric morbidity (Eastwood & Trevelyan 1971); secondly, the present study employed a similar technique to examine the relationship between chronic neurosis and social adjustment.

Design and Method
The aims of the enquiry were, first, to test the hypothesis that clinically-identified neurotic patients are characterized by impaired social functioning; secondly, to examine the nature and frequency of any characteristic social difficulties. To this end, a comparison was made between a representative sample of chronic neurotic patients and a matched control group of mentally healthy persons drawn from the same general practice population.

Measurement of clinical and social variables: Two standard measuring instruments were used: a psychiatric interview specially designed for use in general practice and community surveys and a semi-structured social interview which can be administered independently.

The standard psychiatric interview, which has been described elsewhere (Goldberg et al. 1970), generates a series of 22 item-ratings based on reported symptoms and abnormalities observed at interview, a psychiatric diagnosis and an overall severity score. It has been shown to give highly reliable ratings when administered by trained clinicians.

The standard social interview, also found reliable in a joint-interview situation, contains sections on living conditions, occupation, family income and finances, child management and personal interaction with other members of the household, relatives, neighbours and workmates. Each item is rated on a 4-point scale ranging from 0 ('satisfactory, no difficulties') to 3 ('severe difficulties or dissatisfaction') and assigned to one of three principal categories. The framework of the interview is set out in Table 1. Each of the three main groupings cuts across the areas of social functioning previously listed; for example, the score for material conditions comprises ratings on housing, income, handicaps to social activities, &c. It was hoped that this approach would serve to localize dysfunction and thus to define more precisely the need for social intervention and support.

Selection of index and control groups: Patients were selected from the NHS lists of eight practices in Croydon and south-east London, by means of a special record of surgery-attenders kept for one month by each practitioner. Individual practices were taken in sequence, so that the time-sample of consultations was drawn in a different month for each.