"PSYCHIATRIC DRUGS AND THE GENERAL PRACTITIONER"

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A widespread feeling exists that General Practitioners prescribe greater quantities of psychotropic drugs than patients actually require. In Australia, for example, the figures recently released indicate that minor tranquillizers are the commonest form of prescription written for patients. At the same time, doctors working in intensive care units in general hospitals, are extremely aware of the fact that depressed patients are prescribed large quantities of extremely dangerous drugs, as a result of their experience of the treatment of patients following suicide attempts. In this paper, I would like to consider some of the factors which influence the doctors' prescribing habits and some of the consequences of this behaviour.

General Practitioners are clearly individuals working under considerable pressure. The time which they are able to devote to individual patients is limited, and in this short encounter, they are expected to evaluate a patient's psychological, social and biological functioning. For this task they are often ill-prepared. For many years, medical schools have emphasized the biological aspects of medicine at the expense of the psychological, and as a result, the doctor emerges equipped only to evaluate biological dysfunction and to dispense non-psychological types of treatment.

Against this setting, we have a situation in which practically every patient seen by a General Practitioner suffers some form of emotional distress, and a substantial percentage suffer from conditions which are essentially psychological.

The factors which might result in unsatisfactory prescribing habits are fairly obvious in the case of certain General Practitioners. As indicated above, these habits may be due to poor training which, in turn, generate negative feelings towards patients with conditions which the doctor is ill-equipped to understand and treat. In the face of patients with psychological problems, the fully-trained doctor becomes anxious and defensive and may show his hostility to the patient overtly or covertly. In some cases, doctors, are quite out-spoken about their feelings, and may tell patients that they cannot believe that they have anything the matter with them. Others may not express this belief verbally, but indicate by their manner that the patient is unwanted and that he is being given a prescription essentially to terminate the interview.

The use of prescription writing as a means of terminating interviews is an extremely common and, perhaps, an understandable habit. There is no doubt that by the writing of a prescription the doctor wishes to indicate that he is not rejecting the patient but continues to be concerned for him and is attempting to alleviate his problems in some way. Too often, however, the patient is well aware that the tablets are not given with any sense of conviction and he feels rejected and misunderstood. It is not unusual, in fact, for the patient not to take the tablets at all.

In this regard, it is interesting that doctors often rationalize their need to prescribe tablets by saying that patients expect to be given something. That this is a rationalization, is supported by the fact that many patients coming to psychiatrists, complain that their doctors have given them tablets rather than explore their problems, and it has been quite obvious, in listening to such patients, that they were fully aware of the fact that the prescription of psychotropic agents was not the answer to their problems. This probably explains why such patients often neglect to take their tablets as directed.

The other side of the coin, as it were, is the tendency to under-prescribe in general practice. It is not uncommon to find that a patient has been prescribed psychotropic drugs over a long period of time, but in rather minimal doses. The psychiatrist working in a hospital setting, finds it surprising that such small quantities of an antidepressant or a tranquillizer could have been prescribed for the diagnosed condition, and has difficulty in understanding why the General Practitioner should expect this dosage to be of any help. It is interesting to reflect, on the reasons for prescribing such small doses. Clearly, one explanation may be, that the doctor fully realises that the patient does not have the sort of condition which might be expected to respond to the psychotropic agent, but rather than prescribe a completely inert substance, somehow assuages his feelings of guilt, by giving the patient a tablet which has at least

some minimal potency. A further possibility is that General Practitioners have become aware of troublesome side-effects when patients are given psychotropic agents in a community setting. It is a common observation that out-patients are far more likely to report side-effects when given antidepressants or tranquillizers when compared to in-patients. This probably explains the high drop-out rates from drug trials carried out with out-patients. Therefore, the General Practitioner's tendency to prescribe low doses may reflect an awareness of the ways in which these agents affect patients who are treated outside hospital while engaged in their normal occupations and activities. It is difficult to believe, however, that at these low doses, there may be some factor which results in effectiveness equivalent to higher doses given in the in-patient setting.

What then is the answer to the General Practitioner's dilemma? How is he to cope with the enormous numbers of patients coming to his surgery in the time which he has available? There is obviously no single solution. A step in the right direction would seem to be the trend towards General Practitioners working in group practices, supported by social workers and other community workers who are able to counsel and support patients experiencing substantial psychosocial stress. The General Practitioner himself, can improve the situation by sharpening his skills related to the assessment of psychosocial factors in all illnesses and his capacity to engage in crisis intervention activity when this is appropriate. Graduates emerging from medical schools now are clearly better equipped for this task than were the counterparts a decade or two ago. With the improvement of counselling skills in General Practitioners, and their enhanced capacity for working in crisis situations, I feel one can be optimistic about the future and predict that psychotropic drugs will be prescribed in the general practice situation with increased accuracy and appropriateness.

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The introduction of psychiatric drugs to the general practice of medicine is of particular importance to South-East Asian countries.

There is a shortage of trained psychiatrists everywhere, but this shortage is acutely felt in developing countries. No training programme will in the near future be able to turn out adequate numbers of psychiatrists, to meet the demand for trained workers. This situation is increasingly aggravated by (a) rapid social change with its concomitant increase in incidence of mental disorders and (b) the population explosion.

Seen in this context, we can conclude that the use of psychotropic drugs in general practice, which can be regarded as the integration of mental health principles in public health, is not only a feasibility, but a *necessity*.

The involvement of the General Practitioner has a number of practical consequences:

(1) it will necessitate the development of more intensive and extensive programmes both on an undergraduate as well as on a post-graduate level. In this respect, it is also deemed necessary to extend such programmes to other residency trainings such as pediatrics, gynaecology and other branches of medicine.

(2) the curriculum of the programme should focus on topics such as the effects and side-effects of psychotropic drugs and the integration of those drugs in psychotherapy.

(3) the competence and limitations of the non-psychiatrist in dealing with psychiatric patients, and when to refer to the psychiatrists.

It goes without saying that the implementation of such programmes necessitates also the develop-

ment of psychiatric consultation services which again entails the development of more and better psychiatric training and hospitalization facilities.

Doubts have been expressed by some psychiatrists lest the General Practitioner might take psychiatric patients away from their practice. These doubts have no grounds as has convincingly been proven in many places; also in Jakarta where a heightened awareness on the part of the General Practitioner has led to an increase in referrals to the psychiatrist.

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Psychotropic medication has always been known. Food intake can, in a sense, be the psychotropic medication, and all of us have on occasions personally experienced this truth. In many cultures alcohol is the layman's psychopharmacopeia, and it is greatly effective in the majority of cases. In western cultures, it can often be said that the psychiatric cases seen by doctors are those who are beyond the help of alcohol intake. It appears that the layman's psychopharmacopeia, ie. alcohol and nicotine, have been instrumental in buffering the stresses of the first industrial revolution in Europe and the United States. It would seem that present approaches to the hoped-for containment or eradication of toxic habits such as these should be based upon a more comprehensive understanding of the role of these and of the more "modern" consumption habits.

Now we must focus our attention upon psychopharmaceutical agents used by doctors. Up to Delay and Deniker's introduction of Chlorpromazine in 1952, the doctor's psychotropic drugs were mainly sleep-inducing agents such as the millennia old opiates, with the exception of Reserpine which had been made known to Western medicine by Sen and Bose's paper in 1931 as a psychotropic agent.

The pre-neuroleptic psychotropic drugs had mostly been used by General Practitioners to sedate their neurotic or psychosomatic cases *"ut aliquid fieri videatur"*, and their role in psychiatric hospitals had not been very important. With the introduction of the first true neuroleptic, the psychiatrists became nearly the sole proprietors of effective psychotropic medication. But in the same decade, the minor tranquillizers were introduced, and they immediately found their way into general practice. Within months from their introduction, the consumption of minor tranquillizers by outpatients began to exceed the consumption in psychiatric hospitals. At the same time, the necessity to continue neuroleptic treatment after discharge led to increasing involvement of general practitioners in the use of neuroleptics and the same happened when antidepressive; agents were introduced.

By now non-psychiatric doctors were dispensing the bulk of psychotropic medication practically everywhere in the world. This is also a consequence of the relative scarcity of psychiatrists. i.e. nine in Malaysia, a hundred in Indonesia as opposed to the overabundance of patients with emotional, psychological and psychotic disorders.

It is quite obvious that adequate training and information concerning psychotropic medication is more urgently needed for General Practitioners and non-psychiatric specialists than for psychiatrists. It is no use to complain about General Practitioners giving inadequate dosages of antidepressive drugs, muddling up the clinical picture, or to demand that they leave antidepressant and major tranquillizer treatment to the psychiatrists. There is nobody to relieve the General Practitioner from the need to attend to such problems (unless somebody should prefer to introduce barefoot doctors for that purpose). But there is an obvious trend towards indiscriminate dispensing of psychotropic drugs in developing countries as well as in the western industrial countries. If we are to believe, for a change, what the drug representative

tells us when we ask them, it would appear that many General Practitioners do not know the difference between an antidepressant and a minor tranquillizer, while they use the difference between the prices as a guideline for their psychotropic treatment.

I feel that their quandary can be explained, at least in part, as a result of affluence of both brands of drugs and candidates for psychotropic treatment. In Volume, 3, Number 1, January 1973, of the DIMS (drug index for Malaysia and Singapore) there are thirty tranquillizers and three hypnagogic and four antiemetic tranquillizers, five amphetamines, seventeen antidepressives, five gastrointestinal sedatives which are also called spasmolytics, based upon tranquillizers, six antiallergics containing tranquillizers, one anabolic agent containing tranquillizer, five anti-obesity agents containing amphetamines and even tranquillizers, and these are altogether seventy-five brands of psychotropic drugs that are now available in the country. On the other hand, the percentage of patients with psychological or emotional or psychotic disorders in General Practice is very high everywhere in the world where people have given up the habit of dying early from undernourishment and infections and infestations. In some western countries, thirty to fifty percent of patients in general practice have been found to belong to these categories. This kind of development is often wrongly classified under "civilization disease" and hopefully correlated with increased stresses and strains from modern ways of life. I think it is more an effect of survival. If you live longer, you will experience more frustrations and have more emotional catastrophes which you cannot cope with for want of compensatory boons. This kind of development is bound to increase in Malaysia all along with improving living conditions being the direct consequences.

Where there is no means of warding off the future increase of psychosomatic patients because the art and science of emotional hygiene has not even yet been invented in contemporary industrial society. The only way to streamline this situation would be to make it simpler for the non-psychiatric doctor to use psychotropic medication.

Since most of the brands are really redundant to the General Practitioner, and since he simply cannot lose much by not using the very newest products before they have acquired a good place in hospital medicine, we should propose a simple list of *needed* psychotropic drugs with which all general practice patients can be satisfactorily served unless they develop an allergy or an acute severe psychosis.

This list, if derived from my own experience with psychosomatic patients in neurological practice, would contain:

1. The neuroleptic or major tranquillizer, Chlorpromazine, for continuation of the treatment of psychosis after discharge or as an initial treatment of acute psychoses before admission.
2. The minor tranquillizer, Chlordiazepoxide, for anxiolytic treatment of outpatients.
3. The minor tranquillizer and muscle relaxant, Diazepam, for quick sedation, relaxation and sleep induction.
4. The more sedative antidepressant, Amitriptyline, for depressions with marked vegetative involvement.
5. The more stimulating antidepressant, Imipramine, for the treatment of more apathetic depressions and those depressions which do not respond to Amitriptyline.

I think that such a guideline would be a first step towards a more rational treatment of emotional and psychiatric problems in General Practice. It should, of course, be followed by methodical and very brief training of all non-psychiatric doctors in the specific art of General Practitioner Psychiatry, notably in the psychotherapeutic approach.

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As you know, this is an exhaustive subject and to be comprehensive is to fail to illuminate important issues. I have decided therefore to emphasize one facet of General Practice which hitherto has not had academic exposure in this part of the world, and even elsewhere, has mostly been taken for granted, and whose psychiatric implications with General Practice cannot be over-emphasized.

General Practice is the oldest of the medical disciplines while Psychiatry is relatively new and Psychotropic drugs newer still. In this context you might wonder what psychotropic drugs were available to the General Practitioner some 40 years ago, let alone, the Psychiatrist. True sedatives, hypnotics and narcotics were available, but certainly none of the wide range of anxiolytics and antidepressants as we have them today, yet the General Practitioner was not completely unarmed. He had one wonder drug which he used with great skill and still uses today. This drug is not in the books; you will not find it in any of the Pharmacopoeias, but like any drug it can be subjected to pharmacological analysis. This drug that I refer to is none other than the doctor himself. The most commonly used drug in General Practice is the doctor himself and the most important psychotropic drug in General Practice is again the doctor himself. What is this "doctor" drug? Is this a new dimension in thinking? It has for too long been equated with bed-side manners which is a dangerous half-truth. The "doctor" drug I refer to is the sum total of his personality, the dynamic dialogue that occurs in history taking, the professional touch with which he examines the patient, the authority with which he pronounces his diagnosis, gives counselling and comfort and finally, the confident air when dispensing the bottle. All these add up to this all important drug "the doctor". The "doctor" naturally like any drug, has its dosage, mode of administration, duration of action, acceptability, tolerance, addiction and expiry date in some,too! These are more than metaphorical expressions. The successful General Practitioner is one who, all things being equal, is able to prescribe himself in the right dosage, at the right time, for the proper duration and without any side-effects. Having expounded this concept, this real everyday dispensation of the "doctor" drug that goes in every surgery in town, I should like to turn to the more mundane pen, paper, and pill stuff, leaving the even greater importance of the "doctor" drug in psychiatric situations to fertile. Freudian minds.

A host of psychotropic drugs are prescribed by the General Practitioner daily, but not all of these (unlike as in the case with psychiatrists) are for psychiatric needs. A sizeable portion of these are for non-psychiatric conditions. The phenothiazines make the best anti-emetics and are excellent for vertigo, a first choice for hiccoughs, and a wonderful uterinal muscle relaxant. The muscle relaxant effect of Diazepam are harnessed by the General Practitioner for use in his spastics, myalgias, basal ganglia lesions and obliquely in status epilepticus. Amituptilline and enuresis are by-words among General Practitioners. In this manner, the list becomes quite endless.

Looking at the other side of the coin is the use of psychotropic drugs, by the General Practitioner for psychiatric situations. Here we find him quite free with their use because he is pressed for time. This is unfortunate to some extent in that though he is ideally poised to play the role of the dynamic psychiatrist, he has become, by force of circumstances, a convenient cross between the dynamic and the organic psychiatrist. In his choice of drugs he has often been found to reflect, in a large measure, the prescribing habits of the regional psychiatrists with whom he has rapport.

In summary, therefore, I would like to emphasize that the most important psychotropic drug in General Practice is the doctor himself and an understanding of the pharmacology of this "doctor" drug is as important, if not more so, than that of the various psychiatric sample bottles and pamphlets that adorn our consulting tables.