REVIEW ARTICLE

RESEARCH INTO THE PSYCHOTHERAPEUTIC ASPECTS OF GENERAL PRACTICE: PROBLEMS AND PROGRESS*

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THE work reported here had its beginnings in curiosity about the effectiveness of courses in psychotherapeutic medicine for general practitioners. It soon became plain that an investigation of knowledge in this field would straddle at least three areas: (1) research in general practice, (2) training for general practice and (3) psychotherapeutic aspects of general practice. Exploring the state of the literature in these fields is complicated by the fact that the professional entity which is called general practice may wear different cultural faces. In West Africa (Cobban 1963) and other developing countries (Khan 1965), the general practitioner is an urban phenomenon and serves mainly the upper socio-economic classes. In Great Britain (Davies *et al.* 1962) and other western European nations (Fry 1961), he is the overworked mainstay of government managed health services. In the United States, general practice seems a concept and a dream dying hard. It is discussed frequently in the same tone as a patient on the critical list. Its decline is sorrowfully documented (White 1964) and its demise is regularly foretold (Silver 1958). Some point out the patient's natural stamina (Brown 1964), but an index of the profession's concern may be glimpsed in its writings: *Cumulative Index Medicus* for 1964 lists 44 articles dealing with the future of general practice.

Along with general practice, the literature reflects an increasing interest in assessing and improving the quality of all medical care.

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Investigations have been made of patients' feelings about doctors (Cahal 1963), and a common finding is that there is much positive feeling toward the known, personal physician but more than a little hostility toward 'doctors'—an abstract, unknown and powerful group. In the origins of these feelings, psychological skills are an important issue for the public (Editors, *J. Coll. gen. Practit.* 1964) as well as the social scientist (Simmons 1960). Determining the quality of medical care has become such an urgent question that one recent review of this literature appeared in a lay magazine for consumers (Editors, *Consumer Reports* 1965). An excellent annotated bibliography with 195 references is available for professionals in the field (Anderson and Altman 1962). Hospital audits, record studies, questionnaires (Ford 1965), ratings by colleagues (Crosbie and Gilberstadt 1961) and direct observation (Kroeger *et al.* 1965), all have been used with some success. But despite gains in knowledge and methodology, the problem remains clouded by the complexity of the issues. For example: Patient need and patient demand for medical services are not necessarily the same (Davies *et al.* 1962). At present, designing and maintaining of medical record systems is far from optimal. One disenchanted researcher (Myers 1961) comments thus: ". . . (the patient) leaves the hospital in one of two ways, alive or dead. Any other classification is sheer whimsy". The most elusive concept of all for medical care research is the 'good' doctor. It is easy to fantasy one or even identify one, but definition is difficult. Price and his colleagues (1964) began with 200 measures of physicians' performance, reduced these to 80 and then used factor analysis. Their conclusion is that any easy categorization of the good physician is at best unlikely in the near future.

Research in general practice

Research in general practice has been stimulated by strong currents of public and professional concern. Because of the rapidly increasing number of papers in this area, we have focused mainly on work done since 1960 and given special attention to survey articles which may be of use to the reader with limited time. General practice has been investigated as a training ground for student physicians, as a locale for research, and as a phenomenon for study in itself.

General practice as a training ground

There seems little doubt that young physicians can learn something very special and valuable by watching a general practitioner at work. No outpatient department can really simulate medical practice (Collings 1953) for its excitement (Turner 1964) and methods (Graves 1963, Northern Home Counties Faculty 1963) are unique. In Edinburgh (Scott 1956), a general practice has been made a

teaching unit of the medical school and there is benefit to both parties in this learning situation. As he teaches and comes to serve as a model for the young, the general practitioner may lose some of his sense of professional isolation and may be better able to consider nagging concerns about professional worth.

General practice as a locale for research

General practice has appealed to many as an excellent *milieu* for clinical research. In Great Britain, one article (Wheatley 1963) reported 150 general practitioners taking part in drug trials with a central clearing house set up to manage coding and the maintenance of the double-blind design. Similar efforts (Frohman 1961) have been suggested in the United States. Over 25 incidence and epidemiological studies have been reported by general practitioners in Australia (*Aust. Coll. gen. Practit.* 1965, Radford 1961) from treatment of dog-bite through Raynaud's phenomenon in users of chain saws. In 1961, the Director of Research for the New Zealand College of General Practitioners reported (Marshall 1961) 12 committee and four individual research projects in progress with a number already completed. Included in the latter were: "A follow-up of chronic hysteria" and "The role of the family doctor in sex education."

General practice as a subject for research

The information explosion in general practice research has produced a number of review articles. There are some for those interested in broad coverage of the field (Editors, *Canad. med. Assoc. J.* 1964, Editors, *New Engl. J. Med.* 1963) and two articles which combine an excellent summary of the literature with a critique of methodology and results (Lees and Cooper 1963).

Theoretical considerations

Along with experimental studies, there have emerged theoretical considerations of the nature of general practice, the practitioner and most particularly his relationship with his patient. These theoretical contributions group themselves in two areas: psychological and sociological.

Among contemporary scientists writing on the psychodynamics of the doctor-patient relationship, the name of Michael Balint must be in the forefront, followed shortly by that of Enid Balint. A survey of the work of the Balints and their colleagues at Tavistock Clinic is beyond the scope of this review, but a concise historical summary of these activities has recently appeared (Balint 1966). Beginning with the book, *The doctor, his patient and the illness*, Balint has begun and maintained a revolution in training techniques and conceptualization, and a chronological review of papers (Balint 1957, 1961,

1964, 1965, 1966) gives a strong sense of the continuing force and magnitude of this work. A listing of the ideas generated will have familiar overtones to those familiar with the field: the patient's offer—the doctor's response; he who asks questions, gets answers but not much else; negative findings must be explicitly stated and evaluated; whole person pathology; iatrogenous and autogenous illness; organized and unorganized illness; the doctor's apostolic function; the drug doctor. Colleagues and students of Balint have helped to swell the tide of information about general practice and these studies will be referred to as we consider the various research areas.

As with any historical event, the theorizing about medical practice had its precursors. As early as 1938, Houston had written of the doctor himself as a therapeutic agent, and in 1929, Levy described and documented the integration of the physical and psychiatric examination. If scientism plagued medicine after Flexner, it can also be said that recurrently voices were raised in defence of humane virtues. Of all, the most famous of this century is perhaps Peabody (1927) whose lecture on functional illnesses ended with the now famous words, "The secret of the care of the patient is in caring for the patient". But whatever the precursors, active interest in research in medical practice and its psychological aspects began its main acceleration after World War II.

About the same time, interest in the world of medicine roused in the social sciences. L. J. Henderson (1935, 1936), a physician and a sociologist, had considered the subject of the practice of medicine as applied sociology. But in the late 1940's, the tide of studies began in earnest. Of the early post-war writings, the contributions of Caudill (1953) and Parsons (1951) stand as landmarks. Not without chagrin, doctors realized that they could be studied as part of a social system, and social scientists discovered a new subfield for their endeavours. The extent of the work produced in this field is summarized in reviews and bibliographies (Pearsall 1963, Polgar 1962, 1963, 1964) and in the appearance of collections of articles, each one by an area specialist (Clausen and Straus 1963, Jaco 1958). Sociologists have commented on the increased governmental influence in medicine and considered the implications for the operating system of 'client-control' (Freidson 1960), 'third-party medicine' (Field 1961) and the 'role-conflict' in bureaucratic medicine (Ben-David 1958). Becker *et al.* (1961) studied fledgling doctors *in vivo* and Bloom (1965) examined medical education from new angles, e.g., how similar are the superordinate–subordinate relationships in a medical school to those in a prison, factory or college?

As foundation knowledge grew, the physician himself became a focus for attention and the doctor-patient relationship proved as

provocative of theoretical speculation for social scientists as for psychiatrists (King 1962). For Wilson (1963), the doctor-patient relationship was a 'therapeutic subsystem,' a complex network of social roles, and Buck (1959) saw it as strained by a number of cultural and economic forces. Bloom (1963) and Szasz and Hollender (1956) constructed models of the doctor-patient relationship. Szasz stressed the balance of control in the dyad and Bloom portrayed the multi-layered cultural and subcultural matrix within which the relationship is imbedded. Zola (1963) investigated the decision to go to the doctor and found that it had far-reaching social and psychological implications as well as the familiar clinical ones.

Descriptive studies of general practice

Most of the available studies of general practice seek to describe it; a smaller number have sought to judge its effectiveness. The descriptive studies can be summarized along two parameters: the way in which the data were gathered and the issues which were the focus of the investigation.

Methods of data collection

It reflects credit on the scientific curiosity and the stamina of general practitioners that there are over 50 reports in the literature of research conducted by doctors on their own practices. Of these studies, 35 were done by physicians in solo practice. Why should an overworked doctor and particularly one without help, expend his time and energy on research? Perhaps one reason is that this work provides a change of intellectual pace and has educational value (WHO Report 235). It may also be that research eases somewhat the loneliness which Crombie (1963) has described so eloquently: "The professional isolation of the general practitioner is a situation which obtains in no other branch of medicine, or indeed in any other profession. There is no colleague at the GP's elbow . . . There is no one who can, in day-to-day contact, provide that stimulus to self-criticism and reassessment of ideas and attitudes which is part of all other medical life." Whatever the reason, the studies we will summarize so briefly here represent hundreds of thousands of man-hours of work and they have made a solid footing for more elaborate research.

Pickles (1949) reported epidemiological findings in his practice from 1931 to 1948, well before the coming of the National Health Service provided the impetus to formalize and standardize physicians' record keeping. Since 1948, perhaps because of the changed system, British general practitioners have written steadily about their work. Some of the most recent articles have included: seven and ten years summaries (Henderson 1965, Weller 1963); a detailed time and motion study (Jeans 1965) and a unique investigation of differ-

ing morbidity patterns in two distinct geographical areas (Hardman 1965). From Scotland have come studies (Waterston 1965, Stevenson 1964) substantiating the startling fact that in this area, general practitioners give about twice the number of patient service units (consultations per patient per year) as their English colleagues. Evidence does not suggest that this is because the Scottish doctors have larger lists or spend less time with their patients, and the mystery has been far from adequately accounted for. When a doctor was able to compare his Scottish and Canadian practices, (Noble 1964) he found that morbidity figures were remarkably similar but that there were more new cases in Scotland and many more home visits.

In addition to studies from Great Britain, physicians in India (Kail 1963), Ireland (Maybin 1963) and suburban New York (Seidenstein 1957) have documented valuable practice information.

There are also those who have studied their own practice and progressed from the data to theoretical considerations of its implications. Scott *et al.* (1960) grouped activities into four major categories determined by their psychological rather than classic medical meaning. Doctors, said Scott, use their hands, their tongues, their pens or they listen. Each category could be further fractionated and each might enhance the doctor's therapy in a special way. Kellner (1963) used material unique to general practice to study family ill health. His book abounds with case histories documenting the interweaving of family dynamics with the processes of health and illness. Some families, for example, consult the doctor in pairs, some in clusters, and patterns of surgery attendance can be charted for a stable family group or one which is dissolving. Braun, in his writings (Editors, *J. Coll. gen. Practit.* 1964) admits candidly that he does not use the medical school model of diagnosis. Instead, taking advantage of his intensive knowledge of disease incidence and his patients, Braun has evolved a 'foreshortened' diagnostic system of his own, and feels that most general practitioners do the same. Browne and Freeling (1966) confirm this, "... a consultant (specialist) must justify diagnosis by investigation, the GP has to justify his investigations by his diagnosis". Both authors agree that this system needs to be fully described along with the safeguards necessary for scanning all diagnostic possibilities. Greco and Pittenger (1966) pictured vividly an American general practitioner's life and the changes wrought in it by increased psychological understanding. Their book provides a storehouse of practical techniques for psychotherapeutic investigation within the framework of a practice workload.

In addition to the data from the studies of solo practice, there are studies using the medical group as a unit. These have yielded com-

parison information, not only with the lone general practitioner but within the group itself. Another plan has been a research of both kinds of practice (single and multiple) using the general practitioner's data on themselves but with added personnel to organize and co-ordinate the work (*Lancet* 1961). The outsiders, sometimes physicians, sometimes not, have helped in the documentation and identification of distortions which crop up when doctors record information about themselves. Logan (McLachlan 1964) studying 19 practices noted that most of the doctors felt that they were diagnosing at a symptomatic level in 35 per cent of the cases, at a presumptive level in 25 per cent of the cases and at a definitive level in 40 per cent of the cases. But, one doctor, a bachelor, felt that 86 per cent of his women patients could be diagnosed only at a symptomatic level and seven per cent at a definitive level, and "the other doctors with high percentages at a symptomatic level were also the youngest and the most recently married".

The daily flow of patients which passes through a practitioner's office represents in itself a reservoir of research data. The main problems are those of record keeping, i.e., how can the clerical work of the research be kept to a minimum so that crucial information is noted and patient care can proceed. Struggles with this bulky data have yielded some ingenious solutions, particularly in Great Britain. Kedward (1962) proposed a form small enough to fit into a suit pocket. This brief record could be filled out by the doctor after each patient contact. A number of loose-leaf filing systems have been worked out by the members of the Royal College of General Practitioners. By far, the most widely used of these is that proposed by Eimerl (1960), College of General Practitioners (1963), the famous 'E Book'. J. M. Last reported in 1965 that 200 of these books were in use in several countries, and modifications of this system have evolved, e.g., the 'F Book' concentrating on records of families and the 'W Book', (Kuenssberg 1964) emphasizing work done. There are also researchers who have used the doctors' records without systematization by studying those elements of practice which are universally recorded. For example, studies of prescribing began early in Great Britain (Dunlop *et al.* 1952) and continue to this date. The patient who leaves (Clyne *et al.* 1963) and the one who is referred (Rawnsley and London 1962) have both been investigated and with keen appreciation of the psychic implications of both these kinds of departure. Records have also been sampled (Backett *et al.* 1953, 1954) and then the data amplified by further investigations.

Among these further methods of investigations, interviews and questionnaires have been favourites. In the use of questionnaires, Hill (1951) was a pioneer. Besides sampling consultations, he

collected data on annual income, frequently a difficult topic on which to get information, and found that for the years 1936 through 1939, the incomes of British general practitioners compared poorly with those of specialists. Median incomes for some age groups were almost three times as great for the specialists. Craddock (1963) asked about the physical facilities and attitudes of 80 established general practitioners. He found only 25 per cent contented, and the remainder frustrated by their lack of freedom of movement, lack of contact with hospitals and financial insecurity. Interviews bring the investigator face to face with the doctor and closer to the practice itself. Cronhelm (1961) interviewed 26 general practitioners in Canada and the United States and reported general impressions of the results. Fry and his associates (1962) visited 33 'good general practitioners' in and around London. They reported morale high, doctor-patient relationships good and most offices clean but architecturally 'unsuitable'. Crowded quarters, poor heating and inadequate lighting were among the flaws in physical settings. Wolfe (1963), a physician himself, conducted three-hour interviews with 30 Canadian general practitioners and categorized them according to their agreements with his models as 'comprehensive' or 'non-comprehensive' physicians. Comprehensive physicians, he found, could limit their practices, enjoyed diagnostic problems and were able to express self doubts. Non-comprehensive physicians preferred technical tasks, often felt victimized by their patients and were faring poorly in the competition for hospital status. Bynder (1965), working from interviews with 468 New Jersey physicians, concluded that 'traditionalism in medicine' and the quality of the doctor-patient relationship influenced the kind of psychiatrists doctors chose for their patients.

Focus of data collected

Of studies centred upon experimental issues, three groups have emerged. Emphasis has been placed on: (1) the doctor's workload, (2) the characteristics of his patients and (3) the effect of the structure of the society in which both doctor and patient work.

Sometimes workload studies seem to have been undertaken as an argument for improvement of the general practitioner's lot rather than as a purely scientific endeavour, but happily they add to our knowledge in any case. A recent, excellent review article (College of General Practitioners 1965) summarized 26 British studies in a one-page table. We have already mentioned the higher workload for Scotland and this is well documented, but there are urban-rural and individual differences as well. A four-year Norwegian study (Bentsen 1964) indicated a workload similar to most areas in England, and Logan and Eimerl (1965) recently compared annual rates of consultation per person for home and office in ten countries (not

including Norway). The office-visit rate is highest in Czechoslovakia and lowest in Sweden with the United States about at the median point.

Studies by individual physicians have added to the information about variations in practices within geographical boundaries. In the Netherlands, Van Deen (1965) studied his activities by means of a unit, the 'work-cycle', and then found that these units could be categorized into 32 groups for research purposes. Fry and Dillane (1964) found that their workload remained remarkably constant over 15 years, even though two associates were added to the practice midway in this period. The average estimated time spent with each patient in the office ranges from 15 minutes in New England (Bower 1963) to 5.07 minutes in the Crombie and Cross' (1964) survey of English doctors. Krass (1965) reported seeing 20 patients an hour in his practice and felt that the number could and should be reduced, particularly since 25 per cent of these visits were 'trivial and unnecessary'. Braun (1963), on the other hand, felt that general practitioners must work faster. His patient contacts averaged 1.9 minutes for history, 2.7 minutes for examination and 2.3 minutes for treatment—ample confirmation that some general practitioners are 'minutenmedizin'—indeed minutemen.

That part of the general practitioner's workload which concerns late calls has received special attention. In this literature, Clyne's *Nightcalls* (1963) must receive first mention. No one word *précis* is likely to be adequate to describe the scientific breadth or the psychological depth of this work, for it goes well beyond the subject to explore the doctor's identity and medicine's future, especially as seen in his night world. Jacob (1963) and Richman (1965) have also studied nightcalls and agree that for their practices about 30 per cent of these are difficult pictures. In Scott's (Scott and McVie 1962) work on house calls, he stressed particularly the added work and time involved when the domiciliary patient first returns to the office.

When attention is turned to the doctor's patient, age, sex and diagnosis have been the most frequently examined variables. Eimerl's recent review article (1965) is recommended for a description of the morass of recording differences which make comparison of data difficult but not impossible. In the matter of diagnosis, for example, some investigators record multiple diagnoses for each patient, some record only one. Sometimes the single recorded diagnosis concerns the reason for the visit or it may be the patient's most serious disease. The monumental work of Logan (1958) and his colleagues is an excellent starting place for anyone interested in the field of morbidity, and Huntley (1965) has charted succinctly more recent developments. These works are the encyclopaedias of

general practice, but even in these thousands of tables some trends can be found which may tempt the reader to further explorations. (1) Morbidity patterns are remarkably constant over time. Respiratory ailments are now the most frequent reason for consulting a doctor in England just as they were in 1843 (Holland 1843). (2) In all countries, women appear in the doctor's office more than men. (3) The winter Christmas holiday season is a 'slow time' in most doctors' offices.

We have spoken of the social scientists' increasing interest in the field of medicine. As well as the theoretical contributions already mentioned, there is also considerable experimental work covering a wide range of subjects related to general practice. Bloom's summary (1965) is recommended as a complete and recent coverage. In a small Canadian town, Badgley and Hetherington (1961) found that only 59 per cent of the population saw the general practitioner within a year's time. Slightly more of them saw the public health nurse, but the activities of the doctor and the nurse were poorly co-ordinated. The distinction between the generalist and the specialist is clear only in some western nations: the United States, Great Britain, Holland, Denmark and Australia. In other countries, professional and financial differentiation is much less common (Hogarth 1963, Lander 1963). McNamara and Hassinger (1957) studied physician-family relationships in the Ozarks. One hundred and five of the 152 households felt that they had a family doctor, and alienation from physicians was reported most frequently in the poorer families. Reader and his colleagues (1957) were concerned with patient expectations of their doctors and found that technical skill ran only slightly behind sympathetic understanding in importance.

Two recent articles picture best the growing sophistication among social scientists. von Mering and Earley (1965) have studied the 'crock' and the role of this 'unpatient' in western medical environment. Young (1965) studied socialization and learning as these processes go on in doctors participating in postgraduate seminars in psychiatry. Both these studies portray new methodology for working in a medical setting and increased zeal for experimental field work.

Evaluative studies of general practice

Mention was made earlier of the difficulties involved in evaluating a practitioner's performance. Let us expand these a bit: (1) There is the matter of criteria—how to agree on what is a 'good doctor'. (2) If a physician is to be evaluated, what standards should he be compared with, and on the basis of what data? (3) Practising physicians may feel any kind of evaluation as a threat, and the work cannot be done without their co-operation. (4) Such research is

frightfully costly.

On the question of what kind of data should be used, all evaluators save one (Taylor *et al.* 1965) have felt that to judge a colleague they must see him at work in his native habitat. Furthermore, although evaluation *is* a kind of threat, not only have practitioners permitted it (Fleck 1966, Hadfield 1953, Jungfer and Last 1964, Peterson *et al.* 1956 and Taylor 1954), they have in some cases requested it (Kroeger *et al.* 1965) and in others paid for it (Clute 1963). It is *not* true, as has been suggested, that the physician's consulting room is "the modern analogue of the inviolable sanctuary of the medieval cathedral" (Wilson 1963). Physicians have accepted properly accredited investigation and the disruption it entails (Zabarenko 1964) as part of their professional responsibility.

Scientifically, evaluative work has become more and more sophisticated. Financing still remains a problem. The first educator to venture to practitioners' offices for evaluation was J. B. Youmans (1935). In 1935, he was concerned with estimating the success of four-month postgraduate fellowships which had been offered at Vanderbilt University since 1929. Using questionnaires and his own judgments of the 30 participants as 'before' measures, he compared these with their work in the office after the courses. His yardstick for this comparison was an "ideal high standard of medical practice" and he found improvements ranged from 6 to 125 per cent. Almost 20 years later, Hadfield (1953) and Taylor (1954) again visited general practitioners' offices, but there were some important changes. They spent more time—one to five days—and saw more physicians—Hadfield, 188 and Taylor, 94. All aspects of the doctors' professional lives and work were studied: housecalls, hospital work, relationships with colleagues, training, etc., and recorded data were voluminous. The literature of observing medical practice really began with this work but the criteria used for judgments were still poorly defined.

Peterson's study of North Carolina physicians (Peterson *et al.* 1956) remains the most distinguished single reference in the area. For the first time, criteria for judgment were made explicit, i.e., the weighting given to examination, diagnosis, treatment and physical facilities were explained as was the rationale behind these weightings. In addition, the authors succeeded in getting nearly all of the general practitioners prescribed by their very careful sampling procedures. Finally, these very complete first-hand data were analysed and written up with clinical and stastical elegance. It is easy to criticize a pioneering effort after it has been done. The fact remains that the work of Peterson and his group fired a new approach to the study of general practice and the evaluation of medical care. It also inspired a small (but necessarily) stalwart group of investigators. In 1963, Clute

reported his work using a modified Peterson scale in two Canadian provinces. Jungfer (1964, 1965) has used the same method with success in Australia.

Querido (1963) has summarized evaluative research proceeding over a ten-year period in the Netherlands. One study is remarkable because it describes what may be the ultimate in evaluative daring. Five Amsterdam general practitioners permitted a colleague to evaluate the health of a sample of their patients. Four hundred and one people from 125 families constituted a five per cent random sample from each practice. Each person received a complete physical (including laboratory work), social and psychological examination, and this data was then compared with the findings from the general practitioner's records. Of 553 disorders diagnosed by the experimental procedure, only three serious diseases were found to be unknown to the general practitioner. Two of them were unknown to the patient (one asymptomatic, one neglected). The third case was a patient who knew he'd had lues treated some years previously, but as the disease was now asymptomatic, had not told his doctor about it.

We shall not attempt to present here a summary or a critique of these studies. It is sufficient to note that in general these studies concluded that many general practitioners rated poorly when judged by the standards of academic internists, and that amount of post-graduate education correlated positively with higher performance on these scales.

Training for general practice

The surge of interest in better medical care has carried over into the area of medical education. The effect of medical schools upon general practice and *vice versa* has been discussed (Brown 1964, Silver 1963) and summarized (Lennard 1964) elsewhere, and we have mentioned above the use of general practice as a locale for teaching students. A thought-provoking pair of articles appeared recently on "the adequacy of medical education for general practice". One presented a general practitioner's viewpoint (Stanley 1963), and the other, a medical educator's (Stewart 1963). According to the general practitioner: "General practice is a bastard system with the university as father and community resources as the unwed mother. Is the gentleman going to do the honourable thing and marry the girl?" The medical educator, president of Canadian Association of Medical Colleges, inveighed against formal postgraduate training for general practitioners.

But this trend is evident in at least four countries, nonetheless. The three-year postgraduate course in general practice at the University of Zagreb, Yugoslavia has been described by its director,

Doctor Ante Vulétic (1963), participant physicians (Stampar 1965) and colleagues from other countries (Horder 1965). This full-time programme results in a master of general medicine degree and is reported to have improved the professional and financial opportunities for its graduates. Israel has planned a four-year programme including medical and paediatric training in hospitals and two years of apprenticeship in several general practices. In the United States, Carmichael (1965) has designed a combined graduate and undergraduate programme in family medicine and a similar programme has been proposed in France (Monnerot-Dumaine 1964).

Kent-Hughes (1966) states: "The trend of training is evident in many more countries than . . . named and in some, training is well advanced. In Australia we formulated and adopted a Five Year Plan in 1960 and we spent the next few years preparing details. Course training has been commenced and the first college examinations for a postgraduate membership diploma, similar to the College of Physicians will be held next year. Canada commenced their Three Year Training Programme for the Board Certification this year (1966)."

Psychotherapeutic aspects of general practice

Thus far, we have considered research and training for the whole of general practice. Now, we wish to give special attention to its psychotherapeutic aspects. There is no need to belabour the point that medicine from its earliest days (Block 1957) has included the mandate to comfort the patient as well as heal the disease. When we attempt to be more precise concerning the extent of the general practitioner's psychotherapeutic activities, turgidity sets in rapidly.

We have hinted that it is difficult to synthesize research on the incidence of physical diseases so as to emerge with a coherent picture. Studies of psychiatric morbidity make the earlier problem look like an uncomplicated herniorrhaphy. Ryle (1960), for example, has summarized 15 studies in which the estimate of the prevalence of neurosis in general practice ranges from 5.5 to 75 per cent of patients at risk annually, and Jones (1961) has shifted the range from 2 to 70 per cent. Of Ryle's 15 studies, seven did not define the population.

One core problem is deciding upon what is a diagnostic sign. Table I shows the criteria used by nine authors (not including those mentioned by Ryle), but even these do not encompass all the indicators which have been used. Jacob (1963), for example, felt that housekeeping standards yielded information on 'environmental competence,' and Carstairs (1964) suggested a universal criterion for psychiatric morbidity at the neurotic level in general practice: "Evidence of disability sufficient to interrupt the patient's normal

TABLE I

CRITERIA FOR JUDGING PSYCHIATRIC MORBIDITY

Study	*Physical complaint without physical disease*	*Abnormal psychological reaction to known physical disease*	*Psychiatric symptoms*							*Psychiatric diagnoses*	*Other psychological or social problems*
			Non-specific	*Anxiety*	*Depression*	*Hypochondriacal reaction*	*Obsessional reaction*	*Conversion reaction*	*Delusional systems*		
Cooper *et al.* 1962			X							X	X
Kessel 1960 ..	X	X		X	X						
Lunn 1955.. ..	X	X								X	
Mowbray *et al.* 1961										X	
Ryle 1960		X		X	X	X					
Shapiro *et al.* 1963										X	
Stein 1960 ..	X	X								X	
Stoeckle *et al.* 1964				X	X	X	X	X	X		
Williams 1965 ..	X	X	X								X

activities in the absence of any physical complaint to which this disability might be attributed." Brown (1966) has studied morbidity rates in the families of chronic neurotics. Mills (1963) felt that the diagnosis of psychological illness has been obscured by the closeness of the general practitioner and his patient—"we may find our friends a little odd, but we are loth to perceive them as mad". With all these difficulties, it may be still concluded that much of general practice is concerned with psychological suffering, even though a great deal of work must be done before we know exactly how much.

Evidences abound that this suffering is real to physicians even though it is not yet precisely measured. Textbooks on the subject are multiplying, formal reports have appeared (Group for the Advancement of Psychiatry 1964) and joint committees have been formed—all in an effort to study how the general physician may help in mental health. Any such effort encounters at once two major areas of turbulence: psychological processes present in all doctors, and the uneasy relationship between psychiatry and the rest of medicine.

Both of these topics have received scholarly consideration. The first to comment upon the psychological hazards of being a doctor was Hippocrates: ". . . the medical man sees terrible sights, touches unpleasant things, and the misfortunes of others bring a harvest of sorrows that are peculiarly his". More recently, it has been pointed out (Glauber 1953, Lewin 1946 and McLaughlin 1961) that, through training and experience, defences are built within the physician against these peculiar sorrows and these defences can sometimes act to prevent his best participation in dealing with psychological illness.

Sociologists as well as physicians (Hawkins 1962, Smith 1959) have commented on the distance between psychiatrists and their medical colleagues. This estrangement may show up in a particularly vivid way around the circumstances of a referral (Fitch 1964, Mowbray *et al.* 1961 and Rawnsley and London 1962). The different psychotherapeutic choices of psychiatrists and general practitioners have also been studied (Taylor 1961). But, however thorny the intra-professional or intra-psychic problems, the literature is sprinkled with reports of attempts to solve them. Once again, there are individual practitioners experimenting with therapeutic techniques in their own offices. Pinsent (1962) after a thoughtful study of his own prescribing habits tried something different: for one month, he prescribed a 'stomachic' for all his patients with respiratory symptoms and an expectorant for all his patients with gastro-intestinal symptoms. He reported no real change in therapeutic results and as a result gradually dropped both kinds of prescriptions from his practice. Hopkins (1956) carefully defined what psychotherapy was

in his practice (a laudably rational beginning) and documented the ways in which his practice had changed with time, e.g., increasing use of psychotherapy instead of hormones with gynaecological disorders, more attention to young patients and especially those with children, and better investigation not only of the symptom *per se* but of issues such as, "What does the patient do with the symptom and what does it do for him?" The work of pioneers like these and others (Warren 1962) was beginning to be estimated as early as 1946, when Denker reported on the treatment of 500 psychoneurotics by general practitioners in the State of New York. His conclusion was that for many of the neuroses, the general practitioner could give as adequate care as the psychiatrist.

In addition to work by lone general practitioners, recent years have seen a number of community efforts. Perhaps the most noteworthy example of these mental health programmes is one designed for three rural Minnesota counties with a population of approximately 68,000 (Kiesler 1964). The professional staff spends most of its time consulting with general practitioners and other 'firing line professionals' rather than trying to do psychotherapeutic work itself, and the results in terms of adequacy of care have thus far been most encouraging.

One large development in the United States has been the creation of educational programmes in psychiatry for general practitioners. Sheeley's excellent series of articles (1962, 1963) on the history of such efforts is both complete and literate, and for those interested in current work, the United States National Institutes of Mental Health (1965) have prepared a listing of federally supported facilities offering courses, and the methods and goals of these courses (1965). For a picture of the varied and vivid experiences of psychiatrists in this field, there are the *Proceedings of the Colloquia* held annually by the American Psychiatric Association's Committee on Psychiatry and Medical Practice (1961, 1963, 1964, 1965 and 1966). Teaching methods have varied from weekend conferences (Enelow and Adler 1965) to long-term seminar groups (Watters 1961). While most courses are given in a university or hospital setting, there is at least one report (Grotjahn and Freusch 1957) of teaching in the practitioner's office, and psychiatrist–educators have contributed theoretical considerations of their own problems as teachers (Kaufman 1963) as well as the problems of the learners (Zabarenko 1964).

Outside of the United States, small groups seem more common than large conferences. Seminar teaching has been reported in Germany (Baerwolff 1961), Israel (Boaz-Freund *et al.* 1964, Nelken 1964) and England (Balint 1961, Craddock 1963), and three international meetings have been held for those interested in the small

group method of teaching.

Of some concern has been the issue of how to evaluate the effectiveness of these training programmes. Summaries of methods and problems have appeared (Masserman 1964, Pearson 1966, Zabarenko 1965) and these reports appear calculated to cheer no one, and small wonder. We have already discussed the paucity of studies evaluating general medical skill—how thorny the question of criteria and how difficult their measurement. To attempt to evaluate psychological skills in medicine and the changes in them hopefully introduced by learning this, is a compounded puzzle, with many pieces missing. A psychiatrist's first-hand report (Rorie 1963) may illustrate both the frustrations and the excitement involved in trying to solve this puzzle. "In a ten-minute office call, I witnessed a speculum examination of the cervix, followed by manipulation of a cervical disc under hypnotic anaesthesia, with some psychotherapy thrown in for good measure—all in the same patient . . . and I could not fault any of it." Pittenger has reported (1966) an instance in which two well-trained general practitioners changed the climate of thought about mental health in an entire community of 30,000.

A number of unspecified assumptions have plagued this evaluative research. One is the *tabula rasa* variety, i.e., it is presumed that before instruction in psychiatry, the general practitioner is not doing anything psychotherapeutically—or at least nothing of much value. This has begun to be challenged (Zabarenko 1964). Also challenged, has been the tendency to have teachers function as evaluators (Van Bork 1966) and the tendency to deliver the task of evaluation into non-medical hands (Daugherty 1966).

Thus, we come full cycle. Educational efforts cannot be evaluated until general practice itself is better researched. As always, more work has been done than first appeared and the two jobs—evaluation and discovery—may be undertaken simultaneously with joy and profit for all.

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To understand our needs of today and of the future, it might help to relate them to our needs of a few decades ago. In 1930, there were about 130 physicians per 100,000 persons in the United States. At that time, people were spending about 4 per cent of the gross national product for health and health care. Also at that time, only about 17 per cent of the country's physicians were specialists.

This picture has changed considerably so that now there are about 140 physicians per 100,000 persons; people are spending close to 8 per cent of the gross national product on health and health care and about 40 per cent of our practising physicians are certified as specialists in their chosen area of medical practice. Today, a large segment of the graduate phsyician population is engaged in full-time teaching or research with the consequence that it is not available to render patient care.