INTERIM REPORT

AN EXPERIMENT IN GENERAL PRACTITIONER/PSYCHIATRIST CO-OPERATION

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THIS REPORT DESCRIBES THE FIRST six months of an experiment in co-operation between a psychiatrist and two general practitioners in which the psychiatrist spent an afternoon a fortnight at each general practitioner's surgery.

Background

For several years there has been increasing interest in the psychological aspects of the ill health met in general practice because of the problems which they present. It seems widely accepted that about a third of the patients who consult their general practitioners present with symptoms which express underlying psychological difficulties.

About 90 per cent of the cases of psychological disorder met by general practitioners are not referred to psychiatrists and remain under their sole charge (Taylor and Chave 1964). This is partly because most of them present with somatic complaints and expect somatic diagnoses and treatment (Kessel 1962), and partly because the general practitioner does not consider them to be sufficiently disturbed to justify his making demands on the long waiting lists of a psychiatric clinic, particularly as this often means that a patient receives comparatively little of a psychiatrist's time. Psychiatrists, therefore, rarely have first hand experience of the bulk of the psychological problems of general practice. In this connection, Main (1961) has questioned whether a psychiatrist's skill is put to its highest use when he sees only the developed psychiatric patient and has indicated new developments in the psychiatrist's role in concern for the much commoner disorders and upsets of mental health which he does not at present meet.

Even as regards the established psychiatric cases the system of communication between general practice and hospital is often far from satisfactory; the Medical Care Research Unit's Survey of 600 family doctors, reported by the College of General Practitioners (1965), indicated that over half are dissatisfied with various aspects of the hospital service.

Seminars on psychological problems in general practice, pioneered by Balint (1964), are one of the few formal opportunities for psychiatrists and general practitioners jointly to study patients from their respective viewpoints. The last year of such a seminar run by the writer was spent in

considering the emotional problems of a sample of ordinary (i.e. non-psychiatric) patients seen in general practice (Brook *et al* 1966), and the present experiment arose out of that. Dr St. John Dowling of London, S.W.4, and Dr John Hopkins of London, S.W.14, were each visited once a fortnight to carry out this pilot study during the first half of 1965.

Although epidemiological studies have been carried out in the surgery (Kessel 1962), study of the literature has not revealed an experiment of this type in this country, but one was discovered by Horder (1965) in Prague.

Method of working

Certain points were agreed at the outset:

1. During the 2½ hours at the surgery, the psychiatrist's time was to be at the service of the general practitioner. There seemed to be various possibilities:

(*a*) The psychiatrist could interview two patients and then discuss them with the general practitioner.

(*b*) Both could discuss any psychological problems in general practice that the general practitioner wished to raise.

(*c*) The psychiatrist could supervise on-going cases that the general practitioner was treating by minor psychotherapy.

(*d*) The psychiatrist could accompany the general practitioner on some home visits.

The programming was to be the responsibility of the general practitioner.

2. The psychiatrist was going to the general practitioner's surgery not as a specialist to undertake treatment, but as a consultant to the doctor. He would see any patient referred to him for one or two assessment interviews only, and then he and the general practitioner would discuss possible alternative methods of dealing with the situation, their advantages and disadvantages, and the possible difficulties of each. The psychiatrist would see the patient again after an interval only if the general practitioner felt that this would be helpful to review progress. The psychiatrist would not push any particular approach, and the general practitioner was to feel absolutely free to accept or reject any of the psychiatrist's formulations as he saw fit.

3. To get a full assessment, the psychiatrist and general practitioner would consider each patient under six headings:

(*a*) Psychological problems of the patient that might be aetiological factors of the present complaint.

(*b*) Psychological problems of the patient's family or of his work that might be contributing in some way to the present situation.

(*c*) Fears about his symptoms, the diagnosis and the treatment.

(*d*) The relationship of the patient to the doctor, i.e., to the psychiatrist and to the general practitioner.

(*e*) Summary of formulation.

(*f*) Possible courses of action, including what would be ideally desirable as

well as what would be realistically possible within the framework of the health service.

These findings were recorded and a space on the form was provided for follow-ups.

The work so far

Twenty-six patients have been seen by the psychiatrist for one or more interviews. Over two-thirds of the patients would not otherwise have been referred to the psychiatric clinic.

The general practitioner's reasons for asking the psychiatrist to see the patients can be classified as:

(*a*) Investigation, e.g. What is the patient's distress about? Are there any psychological problems behind the patient's physical symptoms?
(*b*) Advice on treatment, e.g. Can anything more be done than is already being done? If so, what type of psychiatric treatment is indicated?
(*c*) Help with management problems, e.g. If a psychiatrist cannot do more, what can the general practitioner do to help the patient manage as effectively as possible within the framework of his disabilities?
(*d*) General support, e.g. For the general practitioner to share with the psychiatrist the burdens of a crisis or a disturbing chronic situation.

For the 26 patients, it seemed that the most satisfactory form of help for them would be:

(*a*) A period of psychotherapy with a psychotherapist—nine patients.
(*b*) Minor psychotherapy from the general practitioner, with or without the occasional prescription of minor drugs, e.g. sedatives or minor tranquillizers—10 patients.
(*c*) Prescriptions of a major drug, e.g. an anti-depressant, together with the general practitioner's understanding support—seven patients.

The main way, so far, in which the general practitioners have used the psychiatrist's services has been in asking him to see patients, and then discussing the problems with him, and from time to time reviewing with him their progress. To a lesser extent other problems, and patients he has not seen, have been discussed.

Comments on the work

The patients seen so far are too few for firm conclusions to be drawn, but certain comments can be made.

Many patients have said how much they valued the ease and informality of being seen on the doctor's premises, and the relief at not having to go to a hospital with all the attendant anxieties. For a few patients it would have been very difficult to overcome their fears and arrange a psychiatrist's opinion if they had to go to a psychiatric clinic. Several patients indicated their appreciation of the psychiatrist and general practitioner talking over together how best to help them. This was the aspect of the scheme that the general practitioners themselves particularly valued. In all the cases the psychiatrist and the general practitioner felt the interviews to be justified and worth while, but two patients did not concur with this view.

In the course of this work, it became increasingly clear to the psychiatrist that what were referred to as minor psychological problems in general

practice, whether they present with physical or with mental symptoms, are often only minor in the sense that they are not acute, and that this term is really a misnomer; it often covers severe emotional difficulties which may cause prolonged unhappiness or chronic restrictions in life, and these are sometimes major problems for the doctor in terms of how to help the patient.

In seven of the 26 cases the patients' problems came to the surface at a developmental phase, e.g. adolescence, early stage of marriage, mid-life crisis, late middle-age, producing symptoms. In seven other cases an external factor precipitated the breakdown, e.g. a friend's suicide, accident at work, husband's sudden illness. Thus half the illnesses were associated with an internal or environmental ' crisis ' (Erikson 1959).

Sixteen of the 26 described their problems in terms of variations on the theme of loneliness. By this is meant not being alone, but inner feelings of loneliness due to the patient's psychological state. Terms used included: feeling empty, helpless, continually discouraged, fed-up, weary, exhausted, lacking in self-trust. This seems to be an area of distress which leads the patient to his doctor for help when he formulates it in terms of being unwell. The resultant symptomatology frequently presents a difficult problem, particularly in assessing how to respond to the patient's needs.

These visits have helped the psychiatrist to relate his specialty to the day-to-day needs of patients who seek help from their doctors. He has learned to be able to identify with some of the general practitioner's problems, which before he had only been aware of intellectually. For instance, he has actually experienced jointly with the general practitioner the frustration that so much of the time has to be accepted, and indeed tolerated, that what can be done for a patient is often so little compared with what the doctor would like to be able to do.

Visiting each general practitioner once a fortnight has proved to be, in practice, about right. This does not mean that this enables the general practitioner to refer to the psychiatrist or to discuss with him all the cases he would like to, but taking everything into consideration including the demands on the doctors' time, this arrangement has seemed realistic. So far the psychiatrist has been visiting the particular practitioner, not the practice, and has not been seeing patients of other partners.

The College of General Practitioners (1965) has stressed the need for the evolution of a health team, and has suggested that general practitioners and hospitals should improve relations with each other. This pilot study, which is in accord with these proposals, has suggested various lines of future development. For instance:

1. To study further and in greater detail this form of hospital outpatient service and to compare it with existing methods of working. To study the ways general practitioners can use a psychiatrist's visits and to clarify the needs they have for his services.

2. Bearing in mind that most patients with neurotic illnesses present to their doctors with physical complaints (Kessel 1962), to study the psychological aspects of a selected series of patients in general practice with ' minor ' illnesses who rarely get referred to hospital; for instance, a specific symptom, or syndrome,

or those illnesses developing at times of ' crises ', as described, and techniques for helping the patient through them (Caplan 1964).

3. To study a selected series of specific problems, for instance, patients in a certain age group who regularly have three or more spells off work per year. This could lead on to further studies of the role of minor psychological illness in the whole of the patient's economy and of methods of management—for instance in establishing a criteria for deciding when a period of time off work is helpful in enabling him to muster his resources, and when on the other hand it facilitates chronicity.

This report of the pilot study has been written by the psychiatrist and although it is believed to represent the views of all three doctors, final assessment will require full statements from the general practitioners describing the project from their particular view point. A fuller report after the work has been carried on for a further period will remedy this deficiency.

Summary

The article describes the first six months of an experiment of a psychiatrist regularly visiting two general practitioners in their surgeries to help in the diagnosis, treatment, and management of patients with psychological problems.

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