Psychological medicine in general practice

IAN TAIT
Aldeburgh, Suffolk

GENERAL practice is by its nature exposed to the changing needs and demands of the society it serves. It must remain adaptable in form and function or end like the dinosaurus imprisoned by old answers to past needs. That this is so is now so widely accepted that our concern must be with the nature and quality of that response. There is no shortage of experts of all professional and political hues prepared to advise us. But the responsibility for seeing that the last state, both of our patients and ourselves, is better than the first must rest with general practitioners. There is much work now being done to define and agree our present and future functions; to identify what in our past is to be preserved and how it is to be done, as well as in designing new ways of doing new things.

In this work of definition, assessment, and planning for change, no area of our work is more in need of examination than that of psychological medicine and the behavioural sciences as they relate to the work of the family physician. Our society's needs and expectations in this important field have changed profoundly. Contained in this area of work is much that is of value in the tradition of the family doctor, but it has to be re-examined and re-expressed in terms more intellegible and acceptable both to ourselves and to other professional groups if it is to survive the critical scrutiny of the sceptical. One of the difficulties is that there is as yet too little understanding of the character of the change that has overtaken the work of today's general practitioners. The term 'general practitioner' was first used in the early nineteenth century, at which time it meant what it said; that is, a doctor who practiced generally. He undertook a wide range of clinical work, which included all the major specialties. He performed in each to the limits of his competence but it was recognized that this competence would normally be less than that of the specialist in his particular field. Such general practitioners played an essential part in the provision of medical care to communities in the past. Indeed they still do so in those places where the scarcity of specialists, or the financial limitation of patients creates a demand for their services. They may find themselves performing major surgery, transfusing small infants, and setting fractures; all responsibilities that a general practitioner working in the National Health Service today would be unlikely to undertake. Is it, then, that he has become an emasculated shadow of the real doctor he once was? Surely not. The truth is that he has grown a new self but kept an old name. We have to recognize that in systems of comprehensive medical care where the cost of medical treatment is transferred from the sick individual to the society of which he is a member, and in which the services of medical specialists are available to all, many of the old functions of the general practitioner lose their relevance. Indeed the title itself becomes a problem since it invites us to continue to think of the general practitioner as adopting a series of specialist roles. He is seen as a dermatologist, an opthalmologist, a psychiatrist, or a surgeon as the need of the moment dictates: a chameleon without a definable professional identity. This misconception is particularly unhelpful when attempting to understand his rôle in the psychological and sociological areas. The skills derived from the application of these behavioural sciences are essential to his work but their application is in many repsects very different from that of the specialist in psychiatry.

J. ROY. COLL. GEN. PRACTIT., 1971, 21, 221

Balint has rightly suggested that new words are needed to serve this area of psychological medicine to allow the organization of our thoughts, and the expression of our concepts; a task in which he has himself led the way.

If we cannot profitably think of the general-practitioner's work in terms of hospital specialists how are we to approach the task? This can most usefully be done by considering his rôles as a Primary Physician, a Personal Physician and a Community Physician: these we must now define.

The Primary Physician is the doctor who sees the patient first, and to whom the patient normally has open access. It follows that such a physician has particular responsibilities for diagnosis in its broadest sense. Upon his correct assessment of the true nature of the illness or problem that his patient presents to him depends much of the effectiveness of any subsequent treatment, or any other professional intervention that may be undertaken.

The Personal Physician is the physician whose responsibilities in medical care are centred on the individual irrespective of the nature of the disease or problem he presents. His function in this respect contrasts with the specialist who has a responsibility to this patient by virtue of the kind of disease from which he suffers. The title of personal physician does not in any way imply a greater concern for patients but it does imply the need for, and exercise of, particular skills in the practice of 'patient centred' medical care.

The Community Physician has a responsibility for the provision of medical care to an identified population group usually defined geographically. He will thus properly be concerned with the maintainance of health, and the prevention of disease within the community group as well as with the diagnosis and treatment of established disease in individuals.

For the purposes of this study we will consider the functions of the general practitioner in the assessment and management of emotional disorder in terms of these three rôles. But before doing so it is necessary to remind ourselves that although for our purposes they can be considered separately (indeed they can be performed by separate doctors) they are in fact the province of a single doctor in the organization of the NHS and in consequence the divisions will become lost to view in the reality of practice.

The general practitioner has no exclusive rôle in these areas and other doctors will at times act as primary, personal or community physicians. This is particularly true of the community physician, many of whose functions will be performed by doctors working in public health, industry, or in departments of social or community medicine.

The primary physician

A patient's decision to consult his doctor is commonly thought of in terms of his need for conventional medical treatment, but a truer understanding of the situation leads one to see the consultation also in terms of the individuals psychological and social needs and of his learnt behaviour patterns. Often many of these reasons are in part unconscious or unrecognized. Such underlying reasons for a consultation have been called the 'covert content'. The primary physician should be aware of the covert content of the consultation, for only by doing so can he identify the true needs of his patients, and so attempt effective answers to them.

The primary physician will certainly be confronted with cases of serious organic disease requiring accurate, and timely diagnosis in traditional organic terms. But studies from general practice persistently reveal the high incidence of emotionally determined illness presenting to the doctor.

The relevance of these findings for the primary physician lies in the insight it gives

into the nature of the challenge presented to him in the primary diagnostic process. The skills that he needs are not all supplied by the traditional system of history taking and diagnosis. It seems as if the very efficiency of this system in the diagnosis of organic disease can force the interview into a form that makes the assessment of some other factors more difficult. The understanding of psychological aspects of the consultation and the recognition of the psychosocial problems that illness creates or expresses may require a different interview techinque. This needs to be recognized and taught. It may be only a minority of patients that will challenge the diagnostic skills of the primary physician in this way; just as it is a minority that fully extend the clinical skills of the specialist in hospital. Nevertheless when they are needed the necessary skills must be available.

It has been said that the primary physician's task is not so much to attach a label as to explore a situation in all its dimensions—physical, emotional and social. If this points his essential function it also indicates his need for appropriate diagnostic skills. He must be thoroughly trained in traditional medical history taking and examination and be able to apply them effectively in the setting of general practice. He will also need to be able to take a competent psychiatric history. But he requires also a different interview skill which can add a new dimension of sensitivity to his everyday medical consultation. Its use must allow him to recognize and respond to significant signals spoken or unspoken; signals that have to do with his patient's personal psychological functioning in respect to his illness, his life and his relationships. In response to such signals the physician must know when to stop asking the wrong questions, how to help his patient express his feelings about difficult subjects and how to explore related and relevant areas of his psychic life. Such a form of history taking is essentially that of dynamic psychiatry, though the particular way it is applied in general practice might justify a different name. It is the primary physician's responsibility to confront the undifferentiated clinical problem with an ability to vary his method of investigation as that problem defines itself. He must avoid the dualism that can imprison doctors in a false choice between the organic and the functional, the real and the imaginary illness, the medical or psychiatric case. He will try to make a diagnosis in traditional terms but whether he does so or not he will also view illness in relation to a unique personality with a particular life situation which will not only be affected by the illness but will also influence its presentation, its outcome, and the effectiveness of any treatment. Such diagnosis has been variously described as 'total', 'ecological', 'psychodynamic' or 'extended'. To achieve such a diagnosis is the essential task of the primary physician.

The personal physician

Person centred medical care

What is the nature of the psychological skills required by a doctor whose relationship with his patient is founded on the fact of that patient's individuality rather than on the disease from which he suffers? It is surely that he must develop a professional understanding of the way the person functions both as an individual, and as a member of his family and society, and apply this knowledge to the medical care of patients. This implies a practical application of the sciences of psychology, sociology, and also perhaps of ecology and ethology. These are the behavioural sciences and the need to teach them in the undergraduate period is gaining acceptance. The task of building on this theoretical knowledge so that the doctor can apply it to patient care in a realistic way is also beginning to receive attention. The view is sometimes expressed that such use of the behavioural sciences is more properly the concern of the social worker rather than the doctor. This view is tenable for the hospital based specialist, but for the primary and personal physician such a solution is hardly possible. Whether he likes it or not his patients are indivisible, and the kind of problems they bring to him are a confusion

or organic, psychological, and social elements, and very often each component has to be recognized and treated by him at the same time. Indeed this would seem to be the manner of working that characterizes the personal physican. The professional skills required to do this have to be part of the minute to minute practice of the physician. Which leads us to consider the use of psychotherapy in general practice.

Psychotherapy in general practice

We need a better understanding of the kind of psychotherapeutic techniques most useful to the personal physician and of the way he can use them. All psychotherapy is based on the use of the doctor-patient relationship. But since this relationship is different from that of the psychiatrist with his patient so the way in which he uses this relationship must differ. Much of the confusion on this subject felt by general practitioners arises because of the attempt to apply forms of psychotherapy devised for use by the specialist to a working environment that is quite different from theirs. Clearly all psychotherapy requires that the doctor should develop a professional understanding of the nature of the therapeutic relationship he creates with his patient, and of his own part in it. But the way he uses this may need to be very different. There would seem to be a need for personal physicians to be trained in a kind of psychotherapy that can be woven into the texture of his everyday practice. It might be better to think of this as the continuing use of a therapeutic relationship rather than attempting to isolate specific episodes of psychotherapy. Such a therapeutic relationship can only be based on a correct assessment of the patient's psychological situation, past and present. To gain this a competent diagnostic interview must be conducted. The personal physician must be able to carry out an appropriate psychiatric diagnostic interview; whether this is achieved in a single, long interview or in a series of shorter sessions, may not matter, but the organization of a general practice must make it possible for a doctor to carry out long interviews when the need arises.

It is when we consider the use of long-term, specific forms of psychotherapy in the setting of general practice that more difficulty and uncertainty arises. There are serious problems in the application of the more formal kinds of psychotherapy. A doctor to whom his patients have open access cannot control the frequency and reason for his patients' consultations with him. This must influence the kind of psychotherapy that it is appropriate for him to attempt. Traditional forms of brief psychotherapy conducted by psychiatrists can be performed by the general practitioner but even this will involve a reorganization of the way he normally works and to some extent he must step aside from his usual rôle. More prolonged forms of analytical psychotherapy raise formidable difficulties for the family physician. Those who are specially skilled and appropriately trained could do this form of therapy under special circumstances but it is not a realistic or desirable ambition for the majority.

The ability to conduct a competent psychodynamic interview and to use the insights thus gained to use his relationship with his patient to achieve psychotherapeutic results within the context of his day-to-day practice would seem to be a more appropriate aim.

The community physician

The volume and nature of the psychological ill-health presented by modern communities makes it clear that there is little real hope of medical or any other service answering the need in terms of treatment. Mental health education and prevention of psychiatric illness are the only practical way of answering the problem. Such efforts must be based on communities. It will involve many 'caring' agencies both professional and lay. The organization of the NHS places the general practitioner in a natural position to play a central part in this work. Indeed with every person in the land on the

list of a family physician it seems almost inevitable that any organization that starts to meet this challenge should be based on the existing family doctor service. No one could pretend that the present organization of general practice can yet offer much in this field, but with new forms of organization and with the growing partnership with other professions there is surely an immense opportunity for the general practitioner, acting in his capacity as a community physician, to help in this work. Mental health education, forms of crisis intervention, psychological screening of vulnerable groups, the organization and deployment of elements in a community that can contribute to mental health are all areas of work that need our attention. Hardly anything has been achieved as yet, but certain things can be done now to prepare today's doctors for the opportunities of tomorrow. First a change of attitude is required so that we see our rôle in terms of prevention as well as therapy. We need to develop an increased awareness of our responsibilities to the patients on our lists that have not presented themselves as ill. We must encourage and develop working partnerships with other professionals. This partnership must include social workers who, with a rapidly growing professional confidence, are already moving into this field. In this connection the study of the work of medical social workers attached to group practices is of particular significance. The way in which health visitors and social workers and family doctors are to combine their rôles is a problem already with us and one we should be able to solve.

Next we need to design and introduce systems of note-keeping and information recall for the community health team that can form the basis for effective preventive mental health work. These records will need to supply a practical psychosocial profile of patients and families and serve to alert doctors and others to the need and possibilities of therapeutic or preventive intervention. All further development of our rôle in this field must be based on such ground work and the time for preparing it is now.

Summary

The assessment and management of emotional disorder in general practice formed the subject of an Upjohn Study. It is suggested that the practitioner's rôle in this field is best considered in terms of his functions as a primary physician, a personal physician and a community physician.

As a primary physician he needs to be able to integrate a psychodynamic interview technique into his everyday diagnostic process in order to achieve understanding of his patient's needs in organic, psychological and social terms.

As a personal physician he needs to be able to use this understanding to guide the continuing treatment of his patient, by himself or others. Psychotherapy conducted by him must be based on the true nature of the doctor-patient relationship in general practice. Such psychotherapy is likely to be entwined into his everyday work. The development of a capacity to work in this way is seen as a more realistic goal than the attempt to carry out some of the more traditional forms of psychotherapy used by the psychiatric specialist.

As a community physician he is seen as having a vital rôle in the future development of mental health education and prophylactic psychiatric intervention conducted within community groups. His true potential in this field has hardly yet begun to be recognized, still less developed.