Teaching general practitioners about psychiatry*

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THE Royal College of General Practitioners has published[1] an initial statement of the educational needs of the future general practitioner and in it is included a definition of the task of the general practitioner. Briefly stated, this is, to accept the responsibility for making an initial decision on any problem his patients may bring him, to formulate his diagnoses in physical, psychological and social terms and to intervene therapeutically and educationally in his patients' lives to promote their health when such intervention is indicated.

Before considering the content of the training in psychiatry required to fulfil these ends, it is necessary to have some idea of the trainee's knowledge and skills in this subject. The idea that an undergraduate medical education would turn out a fairly completely-trained general practitioner has been discarded. It is now generally agreed that the training of general practitioners in psychiatry has in the past been deficient. The concept of three years post-registration vocational training for the general practitioner has been approved; although there is no compulsion to take such training.

The profession is faced with the need to design simultaneously the vocational training period, so that it provides suitable vocational training for between 600 and 1,000 new entrants to general practice each year, and to supplement the training of many of the general practitioners already in practice.

The contribution that psychiatrists can make to this training does not stem simply from a view of psychiatry as a speciality dealing with the mentally ill, but from a consideration of it as the specialist manifestation of a more general set of knowledge and skills which is inseparable from the understanding of people as individuals whatever their medical problem. However, even if the more formal view of psychiatry is taken, there have been more than enough epidemiological studies which have demonstrated that psychiatrists see and treat only a small proportion of psychiatric disorders and others which show that many people with frank psychiatric disorders are treated by their general practitioners, often in co-operation with specialists other than psychiatrists, when diagnosed as suffering from physical disorders.

From this set of premises, and from the task definition of the general practitioner already given, can be deduced the following educational objectives for general professional, and vocational, and continuing training for the general practitioner.

The trained general practitioner should be able to:

1. Diagnose emotional disorders and mental illnesses
2. Identify the psychological aspects in the management of medical and surgical disorders
3. Demonstrate the clinical skills needed in the investigation and treatment of psychological disorders
4. Demonstrate that he recognizes the importance of the doctor-patient relationship to his consultations

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5. Demonstrate that he understands mental disorders in terms of disturbance of the patient's interpersonal relationships and his social group membership
6. Demonstrate the use of his own personal interactions with patients in diagnosis and in treatment.

The first three objectives are dealt with adequately in general practitioner teaching programmes. To assess what was being done about the second three a questionnaire was sent to the 28 faculties of the Royal College of General Practitioners in the United Kingdom and Eire enquiring what facilities existed for general practitioners to learn skills related to them.

The 22 replies received made it quite clear that apart from the London area general practitioners were not well served with teaching about psychodynamics. A number of respondents had not understood what the second three objectives referred to, although some did say that they identified them with 'Balintomania'.

Questionnaires enquiring about the teaching and learning of psychiatry were sent to those responsible for organizing vocational training for general practitioners. There are at present about 40 such schemes apart from the national trainee scheme. The questionnaires sought information about all six objectives. The methods of teaching psychiatry reported ranged from a six-month period in a psychiatric hospital to group discussions of the psychiatric aspects of cases seen in general practice. There was no consensus and clearly the diversity of methods being tried require assessment to evaluate their effectiveness.

These enquiries showed that there were tutors willing to provide facilities for teaching psychiatry in all its aspects, who could not find general practitioners to take part and paradoxically there were general practitioners who claimed to want such facilities and could not find psychiatrists to teach them. It became clear too that there was misunderstanding about the meaning of the objectives listed. It seems that it would be useful to illustrate them with a case history.

The charge sister at London Airport's Medical Centre, some miles outside our practice boundary, 'phoned me at 7.00 am about one of my patients. She told me that Mrs X had been found at 4.00 am wandering about the airport buildings and had told the Airport Police she wanted to catch a 'plane to see her mother who lived at Buckingham Palace. The husband, when contacted, had said that Mrs X was our patient, he had had enough of her behaviour and would not help.

The solution of this problem required a knowledge of the Mental Health Act and the local mental health services, particularly as London Airport is not in our borough, or in the catchment area of our mental hospital. This is an aspect of objective 1,—a knowledge of the services available in the community to help the mentally or emotionally ill.

Let us take the history back a stage. Mrs X had joined the practice in February 1968 having transferred from another doctor without change of address. A week before the 'phone call from the airport, and in the absence on holiday of one of my partners who normally cares for Mrs X, I had been telephoned by the mental welfare officer, who asked if I knew Mrs X. I had seen Mrs X once about an episode of gastric disturbance. My partner's notes showed a number of consultations about specific pains, which had remained unrelieved. They also remarked on a marital problem. There were letters concerning gynaecological complaints extending over the past seven years for which no specific cause had been found. Some of this history might be felt to be related to the marital difficulties mentioned in my partner's much later notes. I will not hypothesize about such a connection, nor about the repeated consultations for a pain diagnosed by orthopaedic consultants as metatarsalgia, which they were unable to relieve. They can both be taken to illustrate some aspects of objective 2,—'To be able to identify the psychological aspects of the management of medical and surgical disorders.'

Let us return to my 'phone call from the mental welfare officer. She said that she

had been asked to keep in touch with Mrs X in a supportive rôle because Mrs X seemed to be having problems with her husband who seemed to be an unreasonable and rather brutal man. He treated Mrs X harshly, gave her little or no housekeeping, abused her sexually and denigrated her in front of their three children. The mental welfare officer said that she was concerned about Mrs X because she was 'becoming unpredictable'. I arranged to visit Mrs X the next day, with the mental health officer.

At this interview I was accompanied by a medical student. Mr X was present during the interview as was the mental welfare officer. Mrs X was talkative and emotional. She laughed a great deal, but also became angry and tearful in turn. She said that her husband tried to make her do dirty things and that he was a dirty man; that she heard his voice telling her to do these dirty things when he was not present, which she held to prove how dangerous and dirty he was; that her neighbours knew of the dirty things he made her do and so, though it was not her fault, the neighbours thought she was dirty. People constantly talked about her and pointed at her, and she often heard voices telling her how dirty and filthy she was. I made a diagnosis of paranoid schizophrenia. I thought it likely she would become dangerous to herself or to her family if she was not adequately treated. It seemed probable that she could not be relied upon to take treatment at home. Objective 1,—" To be able to diagnose mental disorders". The student also made the diagnosis of paranoid schizophrenia on the basis of the history elicited, elicited despite the angry, aggressive and hectoring interruptions of the husband who was present during the interview. This seems to illustrate one aspect of objective 3,—"To be able to demonstrate the clinical skills needed in the investigation and treatment of psychological disorders".

I offered to sign a Section 29 on the spot. To my astonishment the mental welfare officer, whom I had noticed becoming flatter and more miserable-looking during the interview with Mrs X, disagreed. I asked if she wanted a Section 28, although I felt it to be a time-wasting procedure in this case. No, she said, she did not feel that Mrs X was ill in that way. It was the husband who was the cause of all the trouble with his unreasonable behaviour. I asked why I had been asked to see Mrs X in that case, and she said that she had merely wanted reassurance since Mrs X had seemed to have become a little unpredictable. I made a more polite answer than merely saying "Yes, people who are mad usually are", but this was the tenor of it. No, she could not see her way to agreeing to such an order, but agreed that it would be helpful if I could get a psychiatrist to see her.

What on earth had happened to our devoted, skilled and usually quite objective mental welfare officer? It would not be proper to hypothesize about this, but it touches upon objective 4,—"To be able to demonstrate that he recognizes the importance of the doctor-patient relationship". In this case admittedly not the doctor–patient relationship, but the mental welfare officer–patient relationship.

When the consultant psychiatrist saw the patient he recommended compulsory admission to his hospital. The duty mental welfare officer chose to postpone the matter until the mental welfare officer already on the case would be available, and she, in turn, contrived to postpone it further, although I had already signed the relevant documents. Hence my early morning 'phone-call from the airport.

We have not yet considered objectives 5 and 6. The full history of Mrs X is that she was from a family of intellectuals in Budapest and had come to England as a refugee from the Hungarian revolution and married a mechanic, who had already come over here a year or two earlier for reasons other than ideological. They had married, but were not suited. Mrs X's mother had stayed in Hungary and her father had died. She had tried to send money to her mother, but this had been a source of disagreement between her husband and herself. Mr X had an unattractive personality with a certain animal magnetism and had taken up happily the rôle of the working husband who goes out to

drink at night with his mates, but Mrs X seems to have been ill-trained for a working-class wife's rôle. My partner had correctly come to understand Mrs X's mental disorders in terms of objective 5,—"To be able to demonstrate that he understands mental disorders in terms of the disturbance of the patient's inter-personal relationships and social group membership". He had decided that the mental welfare officer would be suitably placed to act in a supportive rôle on home visits. He had a similar intention, impeded by the language difficulty, but facilitated by the relatively frequent consultations on a physical basis. During these visits he proffered her the support of her fantasy of him as a benevolent, identifiable, fatherly person. This, I think, illustrates objective 6,—"To be able to demonstrate the use one's personal inter-actions with the patient in diagnosis and treatment".

Unfortunately, perhaps because of her being referred with her metatarsalgia by another partner to an orthopaedic surgeon, he lost contact with the patient, and it also seems that the mental welfare officer found herself unable to remain professionally dispassionate in her supportive rôle.

This case history illustrates the six proposed objectives, and it also demonstrates something else. The rôles of psychiatrists and general practitioners in today's society, with today's organization of medical care and distribution of medical man-power, so interlock and overlap that the training of general practitioners, which determines the rôle they will play, must affect all decisions as to how to train specialists. The task defined for psychiatrists will be derived, at least partly, from the terms which define the tasks of the general practitioner. The six objectives listed might as easily serve as objectives for training schemes for psychiatrists.

It is assumed that the general practitioners' teachers will come from the ranks of the psychiatrists, and from those they already have the responsibility for training to succeed them. The various forms of small group techniques seem to be the best way of achieving the objectives for general practitioner reading and learning. The majority of the respondents to my questionnaires were seeking to use small group sessions and are hoping that psychiatrists will help. Many feel that such small group learning is essential for objectives 4, 5 and 6, but not necessarily for objectives 1, 2 and 3, although many schemes try to achieve all six in the same format. This is not surprising if psychiatrists are conducting the groups as it permits them to act in two capacities, simultaneously.

The activities of a discussion group can be loosely divided into task activities and process activities. Process activities reflect to some extent the emotional needs of the individuals in the group and their interactions. Is it by the student coming to understand his actions in terms of group process that he is helped to understand himself and his views of other people. If the group is nominally a task group and if the leader of that group has simultaneous task and process responsibilities then the demands made upon the leader in his two rôles will be very great. These two rôles might be called the resource rôle, providing data, and the leadership rôle, using his understanding of the process activities.

Should not trainee psychiatrists be helped to acquire the necessary skills in conducting small groups? Should they not be taught by these methods themselves? These two questions bring us back to objective 6 which needs a few more comments. It is doubtful if all general practitioners would wish to, or even be able to, achieve this sixth objective of "being able to demonstrate the use of his own personal interactions with patients in diagnosis and treatment".

The caveat is entered because, such use of one's own personal interactions requires a degree of self-knowledge which may not be tolerable to all. Be that as it may, it is certain that no one who has not himself acquired the degree of self-knowledge required for the achievement of objective 6 can monitor others who are trying to attain it themselves and

probably cannot monitor their efforts to attain objectives 4 and 5 either.

Just as not all general practitioners would wish to tolerate acquiring the degree of self-knowledge required to achieve objective 6, some psychiatrists may not wish to tolerate it in order to help others to achieve objectives 4, 5 and 6. This identifies a dilemma for psychiatry as a discipline because it seems obvious that in the absence of general practitioners who have achieved objectives 4 and 5 as well as 1, 2 and 3 the work-load of future psychiatrists will become intolerable.

One of the skills required of a psychiatrist is that he be able to face dilemmas and to cope with them. It is to be hoped that psychiatry as a discipline will be prepared to face, and be able to cope with, the dilemma presented to them by the general practitioner having identified some of his educational needs.

REFERENCE

1. *Journal of the Royal College of General Practitioners* (1969), **18**, 358.

Of the Diseases of the Campaign in Britain, 1746

On the 23rd of April the troops first encamped at Cullen; the next day passed the Spey; and on the 27th, immediately after the battle of Culloden, we advanced to Inverness, and encamped on the south side of the town.

At Strathbogie and Inverurie the duty had been constant, to guard against a surprise; one day's march had been long and rainy, the encampment early, and colds were caught by wading the rivers: all these circumstances concurred to make the sickness considerable. Before the army reached Inverness, about 70 men fell ill, and were left in towns by the way. After taking the field, the inflammatory diseases still increased, and were the more severe, as the season was early, the climate cold, and the camp exposed, in an open country, to piercing winds. The pleurisies and peripneumonies, in particular, were violent, and tended quickly to suppuration.

At Inverness two malt-barns received the wounded; in all 270. There were many cuts of the broad-sword, till then uncommon wounds in our hospitals; but these were easily healed, as the openings were large in proportion to the depth, as they bled much at first, and as there were no contusions and eschars, as in gun-shot wounds, to obstruct a good digestion.

Besides these barns, two well aired houses were prepared for the reception of the sick. The regimental surgeons had, moreover, orders to provide quarters for their men, as they were taken ill, with the liberty of sending to this general hospital such a proportion of the worst cases as should crowd it. By this dispersion of the sick, and the preservation of a pure air in the wards, it was hoped that any contagion might be moderated, if not prevented; tho' it was more than ever to be apprehended, by reason of the smallness of the town, the jails filled with prisoners, many of them wounded, the prospect of a long encampment and camp diseases, the crowds and filth of a place where the markets of an army were kept; and lastly, a morbid state of air, from the measles and small-pox, which had prevailed in the town before the arrival of the army.

All these circumstances concurred to put us upon our guard: wherefore great care was taken to keep the sick divided, and their wards clean. An order was likewise given to clean the jails every day, to remove speedily the bodies of those who died; and to prevent crowding, part of the prisoners were sent on board some ships lying in the road, with a liberty of coming upon deck for the air.

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Observations on the Diseases of the Army. Third Edition 1761. P. 44.