Behavioural problems in general practice

MOST British doctors who were trained before 1968 were brought up to see medical problems within a framework of disease—disease, moreover, which was understood in terms of pathology. The old aphorism "pathology is the basis of medicine" was constantly reiterated and time and again leading teachers referred to seeking the "ultimate truth" in the postmortem room.

It was, is, and will continue to be true that most organic diseases can indeed be understood only in terms of their underlying pathology: thus whatever the changes in medical thinking and teaching pathology will always remain one of the fundamental sciences.

Nevertheless, since the earliest studies of general practice it seems to be a fact that general practitioners are simply not able to diagnose problems entirely in terms of pathology, in at least a substantial proportion of their consultations. James Mackenzie in his appendix to the Departmental Committee on Insurance Medical Records (1920) argued powerfully against the inclusion of a space for 'diagnosis' because often general practitoners simply could not make a diagnosis in traditional terms. He went on to say that if practitioners were so constrained and forced to put pathological labels on their records, research and progress in general practice would be hindered.

In 1958 the Research Committee of the College of General Practitioners, led by Crombie and Pinsent, showed that in only 55 per cent of consultations could doctors make a 'firm diagnosis' in pathological terms.

At first these findings caused uncertainty and guilt in the world of general practice. In most hospital wards consultants had a pathological basis for diagnosis in a far higher proportion of their patients. Indeed hospital doctors became guilty and uneasy only about the very small minority of patients for whom they could not find clear-cut pathology. General practitioners wondered whether they were second rate in identifying pathology and whether their clinical or investigatory skills were less efficient. Furthermore, these findings were published at a time when general practice itself was in disarray.

These results have, however, since been confirmed not only in the United Kingdom for more than 20 years, but across the world by colleagues who had access to all the investigations they needed and whose clinical skill commanded respect. Some other reason had to be found to explain the high incidence of consultations in general practice in which the practitioner could *not* find a pathological cause for the problem presented.

Behavioural sciences

At this stage general practice was greatly strengthened by important insights from the behavioural sciences. Medical sociology, for example, by showing what expectations patients had of doctors, illuminated the consultation in general practice and analysed the role of the doctor in society. It thus began to clarify what actually went on in the consulting room.

Gradually it became clear that patients who did not have disease were often found seeing doctors. One obvious group were those who were frightened and anxious about some symptom whose significance loomed disproportionately large, perhaps because of some previous unhappy experience in the family. Some patients went to doctors just for certificates; others sought to obtain medical support for applications for rehousing or for security benefits.

In the early years, general practitioners tended to look down on these activities as not being a proper part of medicine or a respectable role for a registered medical practitioner. The implication was that if the patient had no pathology he or she was in some way less deserving of the doctor's time. But subsequently reassurance, although at first underestimated, came to be recognized as a rightful role of the doctor and one of great value.

In 1968 the Royal Commission on Medical Education emphasized the importance of the behavioural sciences and recommended that these should be actively incorporated into the training of all doctors, especially general practitioners. As this began to happen, ideas from the behavioural sciences infiltrated general practice education, particularly at the postgraduate level. In 1972 the Royal College of General Practitioners published the *Future General Practitioner—Learning and Teaching,* in which four of the five 'areas' were *not* concerned with health and disease. The percipient headings of Human Development, Human Behaviour, Medicine and Society, and Practice Organization stood in stark contrast to the previous relatively simple pathological framework of illness and their full

significance has not yet been appreciated by some in the medical profession.

The idea that pathology alone determined behaviour was progressively undermined as it became recognized through the results of numerous studies that conscious human behaviour was a key determinant of health (*Journal of the Royal College of General Practitioners,* 1977). Lalonde (1975) laid out the arguments that showed why in future emphasis in western societies was likely to be based on the diseases of lifestyle, or on minimizing what he called 'self-imposed risks'.

In his James Mackenzie Lecture, Pereira Gray (1978) referred to the "disproportionate importance of pathology" and in arguing for a "fundamental realignment of priorities" suggested that the understanding of human behaviour by general practitioners would prove to be of growing importance in medicine.

Psychotropic drugs

At first the extent of behavioural problems in general practice was ludicrously under-emphasized. It is hard to believe that one of the biggest group of problems in general practice could be virtually ignored in the undergraduate curriculum, but this was the case for many years.

Paradoxically it was a pharmacological innovation which exposed this deficiency, and when the new tranquillizers were first introduced the enormous flood of prescribing and the rocketing rise in prescriptions for chlordiazpoxide ('Librium'), and later for diazepam ('Valium'), drew the attention of government, public, and profession to a reality which had previously been underestimated. Despite their lack of training, despite the relentless criticism from all sides, despite the pressure and lack of organization, general practitioners voted with their pens and showed that they clearly understood that many of the problems presented to them were behavioural in origin—by treating them with what was at that time the only behavioural treatment at their disposal—psychotropic drugs.

The vast boom in the prescribing of psychotropics, although universally criticized, can be interpreted equally as an appropriate recognition by primary medical care of the fundamental nature of many patients' problems. It is certainly true that the prescribing of psychotropics has been vastly overdone, that many of these drugs are habit forming, that some patients have difficulty in stopping them, that they may themselves have underestimated risks (Skegg *et al.,* 1979).

It is certainly true that there are important alternative ways of handling behavioural problems; it is possibly true that they are better not treated by doctors; it may even be true that they should not be treated within the primary health care team at all. However, whatever the possibilities for the future, the fact remains that in Britain today about a third of all consultations can be found on analysis to have some important psychosocial component which cannot be entirely understood within a pathological model of illness.

As a result of criticism from within the profession itself (Parish, 1971; *Journal of the Royal College of General Practitioners,* 1973; Malleson, 1973) and from the public (Illich, 1974) general practice has begun to review critically its prescribing policies and is now probably more aware of the dangers than at any time in the past.

Detailed analyses of many consultations in general practice are showing how many patients with 'anxiety state', 'depression', or 'neurosis', are reacting to personal problems in their lives, most commonly relationship problems at home or at work. Important recent work by Brown and his colleagues (1976) is confirming this conclusion.

Colleagues in care

Simultaneously a growing number of clinical psychologists and counsellors in other disciplines have begun to wonder if behavioural problems could be treated within the setting of primary medical care, but not necessarily by the doctor (Broadhurst, 1972; Kincey, 1974; Johnston, 1978).

We publish today four articles by Lamberts (p. 000), Koch (p. 000), Ives (p. 000), and Anderson and Hasler (p. 000), all of whom describe alternative ways of dealing with behavioural problems in general practice. The general conclusion which emerges is that this idea has considerable potential and is well worthy of further research and study. How much or how little the doctor himself/herself should do is still to be determined.

These articles are just a beginning. There are problems about definition, referral, co-incidental medical treatment, and in accurately assessing outcome. Nevertheless, it does seem clear that in managing the continuing request from patients for help with problems about behaviour, colleagues in the caring professions such as counsellors, psychologists, and social workers may, within the setting of the primary health care team, be of considerable assistance to patients.

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Access to primary care

On the whole, while always capable of improvement, the National Health Service did provide an accessible primary care service which was generally appreciated by its users.

Simpson (1979)

ONE of the most valuable consequences of the work of the Royal Commission on the National Health Service has been the decision to initiate special studies of different aspects of the NHS in the United Kingdom by independent professionals, and to publish their reports. In each case the Royal Commission has been careful not to accept their conclusions officially but to make them available for general information and discussion.

The sixth and most recent research paper, published in February 1979, is called *Access to Primary Care.* Its views are those of Mr Simpson and the National Consumer Council and not of the Royal Commission itself and its stated aim was "to concentrate attention on the needs of priority age groups in poor areas".

In looking for suitable districts to study, the Department of Health and Social Security analysed 23 "social stress indicators" which, when ranked, gave Hackney the highest stress ranking. Simultaneously, the annual rate support grant allocation has apportioned Hackney in successive years the "highest needs element" of any English or Welsh authority. On top of this, Stoke Newington is one of the poorest districts of the Hackney borough and was chosen as a "recognizable community of roughly the size needed".

In Rectory, which was one of the wards surveyed, over 30 per cent of the families had only one parent in 1971, and was considered by the authors "the most stressful ward in Hackney Borough".

The other district was the Cockermouth/Maryport area of West Cumbria, chosen because the authors wanted a northern location with a mixture of rural settlements and small towns.

The conclusions of this research must therefore be judged against the background of the areas chosen. This was no random sample of two areas in Britain: it was a deliberate attempt to sample the views of consumers of general practitioner services in an urban area of immense social deprivation. Given the overwhelming evidence that many of the factors governing health and the use of health services are determined by the general social environment, it was predictable before this study started that general practice in Stoke Newington, London, would have its problems.

General practitioners

Of the 17 doctors in north Stoke Newington, one was already over 70 and, in the report's somewhat loose phrase, several were "around retirement age". However, in the doctors' favour was the fact that the area was classified as "restricted".

In both areas almost two thirds of children aged five or over had been with their doctor for five years or more, and over 80 per cent of old people in both areas had had the same family doctor for more than five years.

In examining waiting times, it was found that clear majorities in both areas were seen usually within 10 minutes, and well over 90 per cent were seen within half an hour.

Considerable attention was given to the arrangements for out-of-hours visiting. Deputizing services were used much more in Stoke Newington, and of the 14 occasions when the out-of-hours doctor was slower in coming than expected, on only one occasion was he the patient's own doctor: all the other 13 were "other" doctors, "probably . . . from deputizing services, which they certainly were in some cases" (paragraph 2. 51).

There was some evidence of difficulties in obtaining home visits, but the author concludes (paragraph 2.57): "The overall impression is that patients with chronic or more serious conditions, that is mainly old people, received prompt attention". As far as medical emergencies were concerned: "In all, the question on emergencies—like the subsequent one on use of hospitals—showed prompt attention by general practitioners, ambulance staff, and hospitals".

Throughout this document there is evidence, published for the first time in this country, that parents