increased by 20 per cent and district nurses by 35 per cent, and in the three years from 1976–79 by 14 per cent and 11 per cent respectively. But this only amounts to an increase, from 1971–80, from 0.3 health visitors per general practitioner to 0.4, and 0.5 district nurses to 0.6, and at one health visitor to 5,774 people and one district nurse to 3,777 people in 1979 their caseloads remain far too high.

The quarts appear to be coming out of the pint pots: general practitioners are responsible for more and more of the total care provided by the National Health Service, without any real increase in the share of the National Health Service resources with which to do it. The addition of new principals is a niggardly contribution, when they are largely remunerated on capitation from a stable population. 'Transferring resources to the community' means new spending on health centres, community nursing staff, computerizing FPC records, and new initiatives.

DAVID METCALFE
Professor of General Practice,
University of Manchester

References

1. Office of Population Censuses and Surveys. *General household survey. Annual Reports.* London: OPCS, 1983.
2. Department of Health and Social Security. *Health and personal social services for England 1982.* London: HMSO, 1983.

Is training in psychiatry relevant for general practice?

THE psychiatrist's appreciation of the training needs of general practice is coloured by an erroneous perception of the type of emotionally disturbed patient in general practice, by a misguided approach to general practice training, and by a lack of appreciation of the nature of general practice itself.

Goldberg, in the excellent monograph *Mental illness in the community. The pathway to psychiatric care,* clearly defines the dimensions of the 'referral filter' through which patients pass from community to general practitioner, to psychiatrist.[1] The patients who are not primarily referred to the psychiatrist suffer from minor mood disorders with anxiety and depression. The psychiatrist sees essentially the 'psychiatric' patients with affective disorders, the psychoses, organic brain disorders, and the severe personality disorders. Many psychiatrists thus believe that severe disturbance is common in general practice, and general practitioners are accordingly often exhorted to recognize and treat depression more effectively. The general practitioner needs assistance for the ambulatory patients whom he does not refer, who are likely to comprise more than 90 per cent of the emotionally disturbed population. Only 10 per cent of cases present openly with a psychological problem, so that efficient interviewing detection skills are of paramount importance. Johnston and Goldberg have shown that early detection and treatment of the overt emotional problem results in relief of symptoms and psychological pain, without 'medicalizing' the illness and with probable cost benefits.[2]

Wakefield and Lesser have shown that such patients prefer and need to be treated by general practitioners in their 'home setting', that most of them do not need referral, and few need pharmacotherapy.[3] They want brief and effective help in problem resolution. Thus the training locus for general practitioners should be with their own patients, in their own settings, and not in tertiary care psychiatric settings where the emphasis is on diagnosis and treatment of the major disorders. In these tertiary care centres, it is not easy for general practitioner trainees to be readily accepted by multidisciplinary groups. General practitioners require such training only where some specialized need must be met.

General practice differs from psychiatry not only in the nature of patient population, but in the nature of the practice itself. General practice is a primary contact speciality, offering continuity of care, multiple and continuing points of entry into individual and family systems, with particular time constraints requiring a different interviewing approach, and with a varied practice that involves significant change in the mental set of the practitioner. Their patients do not want long-term therapy and, like the general practitioners themselves, are not impressed by a psychodynamic model, but would rather have a pragmatic, problem-orientated approach. General practitioners need effective and efficient interviewing approaches to detect the covert problems, to discuss them with their patients, and to assist in resolving them; it may well be that they have to be the most efficient interviewers in clinical medicine.

The psychiatrist who works with general practitioners must understand the referral pathways, the way patients present, the need for detection and brief problem-orientated treatment, and the nature of general practice. Psychiatrists must not be wedded to one theoretical model but must be able to use all the major theoretical models for the understanding and treatment of patients. If psychiatry is to be relevant to general practice, then it is the psychiatrist who must go to the general practice setting and teach the general practitioner trainees along with their patients, using approaches that are geared to general practice.

Two key elements must be present in the approach developed for teaching and learning interviewing skills. First, teaching must centre around actual encounters with patients, and secondly around groups. Patients should be seen directly or via a one-way screen, or indirectly through the use of audio- or videotapes, because the reality of the experience evokes the necessary stimulus for the trainee to acquire a conceptual base for the type of problem and to become skilled at interviewing. The doctor is actually involved with a problem that is real, not imaginary. The absent patient is rarely described accurately, and so is rarely recognized at the time of the interview. Groups are the preferred teaching structure, being economical, and enabling the teacher to explore various content areas, to discuss common reactions to patients, and collectively to detect and solve problems. Members of the group can model for one another, can supervise each other, and be responsible for their own learning. Repeated supervision of 'live encounters' with patients in groups, is likely to be the most effective way to acquire such skills.

Lesser has described an approach taught in groups emphasizing actual patient encounters.[4] It contains three key components: a behavioural model for data collection and clear problem description: problem-orientated assessment and treatment: and the use of paradigms or prototypical examples of common problems, rather than diagnoses. The behavioural approach was selected because general practitioners will learn more readily an approach unencumbered by theoretical psychodynamic models. The behavioural approach with its empiricism is more patient- and problem-orientated, and seems to fit best with the time constraints of general practice. It allows for various theoretical models to be used at the point of intervention, rather than at the point of data collection where such use forces the data to fit the theoretical model. In utilizing this approach, conflicting situations are sampled, and three particular sets of behaviours are examined: reported behaviours—vignettes or events occurring in the daily life of patients which serve to show the adaptive as well as the maladaptive aspects of behaviour; observed behaviours—those behaviours, primarily non-verbal, seen by the interviewer in the session; and self-reported behaviours, including cognitive, perceptual and affective components of the interview. A problem-orientated approach was adopted because patients bring problems from their daily lives which they want solved, and when the general practitioner examines the details of these conflicting problems he can introduce methods of quantification and avoid intellectualizing or being abstruse. By asking if the problem would occur normally, in the particular social group and culture, the physician can then ask himself whether the behavioural events are adaptive or maladaptive. By dissection of such events, their nature can be shown to patients, their motivation and capacity for change can be examined, and they can replay the conflicting events in an adaptive fashion.

Patients come with problems producing symptoms and limitations in function for which a systems diagnosis is more pertinent for treatment purposes. For these patients psychiatric diagnoses tend to be sterile labels with limited predictive value for treatment. Patients want help with their behaviour and the physicians want to know which problems must be treated and how to do it. Thus paradigms or models are emphasized, or examples are given of common prototypical patient problems in which particular strategies and tactics are employed to modify or eliminate certain identified maladaptive coping behaviours. Psychiatric nosology has a place with certain disorders such as schizophrenias and primary affective disorders, where the diagnoses have definite reliability and where specific empiric treatments are useful and necessary. As Williams stated, 'Although diagnosis fulfils many functions, the most important for clinical practice is its predictive power for management.' He saw certain advantages in a problem-orientated approach to treatment including: 'It serves as a reminder that different conceptual models of illness can be adopted for different problems in the same patient.' 'By definition, treatment is closely related and directly relevant to the problem.'[5] Paradigms can be taught for such common problems as marital discord and alcoholism, while psychiatric diagnosis can be used for far less than 10 per cent of emotionally disturbed patients.

If a successful partnership is to occur between the two specialties, not only must the psychiatrist come equipped with a knowledge-base and eclectic expertise suitable for general practice and its patients, but general practice must be prepared to identify and treat the problems of 39.6 per cent of their patients who are emotionally disturbed at any given time.[6] They must not abrogate this responsibility.

Pellegrino saw a triad of academic challenges for family practice including, 'Can it make a special and needed contribution to patient care?'[7] A combined training approach can only be successful if the general practice trainers reinforce and support its development. The present situation is not helpful to either specialty, nor to our patients.

A. L. LESSER, MD, FRCP(C)

References

1. Goldberg D, Huxley P. *Mental illness in the community. The pathway to psychiatric care.* London: Tavistock, 1980.
2. Johnston A, Goldberg D. Psychiatric screening in general practice. *Lancet* 1976; **1:** 605-608.
3. Wakefield JC, Lesser AL. Using the psychiatrist: a different approach to consultation. *Can Fam Phys* 1975; Oct: 79-85.
4. Lesser AL. The psychiatrist and family medicine. A different training approach. *Med Educ* 1981; **15:** 398-406.
5. Williams P. Deciding how to treat–the relevance of psychiatric diagnosis. *Psychol Med* 1979; **9:** 179-186.
6. Marks JN, Goldberg DP, Hillier VF. Determinants of the ability of general practitioners to detect psychiatric illness. *Psychol Med* 1979; **9:** 337-353.
7. Pellegrino ED. The Academic viability of family medicine. *JAMA* 1978; **240:** 132-135.