PSYCHOLOGICAL MEDICINE IN GENERAL PRACTICE—A STUDY OF THE TRAINING GROUP METHOD

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In 1958, the Working Party of the College of General Practitioners set up to study psychological medicine in general practice reported, among its findings, that 30 per cent of illness presenting in general practice is of psychological origin.[1]

In 1959, the British Medical Students' Association published a report on the teaching of psychiatry in British medical schools. In this report " the outstanding criticism which the students made of the courses was that they felt that a sound and basic knowledge had not been provided, that only a fleeting acquaintance had been made with psychiatric illness . . .".[2]

Comparison of these two sincere and thorough reports indicates that the doctor entering general practice is singularly ill-prepared to deal with a considerable proportion, almost one third, of the illness which he will encounter. When it is further considered that between five and ten persons in every 100 is suffering from a neurotic illness, and that the general practitioner can reckon to see, in the course of a year's work, from one to two hundred new or established neurotics on at least one occasion[3,4] having made " only a fleeting acquaintance with psychiatric illness ", the need for postgraduate education in this field is emphasized. That more and more general practitioners are becoming aware of this need has been shown by a recent survey of postgraduate education carried out by the College of General Practitioners[5], which states that there is an increasing demand in all areas for local discussion groups, and psychiatric seminars.

What facilities are available to general practitioners in this field of postgraduate education?—and what type of postgraduate education is desirable?

1. Organized postgraduate courses, which may be of three types.

(i) The weekend course, such as those arranged by the National Association

for Mental Health.

(ii) The long course. The one annually held at Ipswich is excellent.

(iii) The extended course, which consists of lectures or seminars held on one afternoon or evening a week for six to eight weeks. Such courses are held at the Maudsley Hospital, the Royal Free Hospital, the Uffculme Clinic at Birmingham, and in association with the Department of Mental Health at the Queen's University, Belfast.

2. Doctors may meet this need by reading books, journals, or papers on psychiatry. It is now possible to obtain recordings on tape or disc from the recording service of the College of General Practitioners, and this has led to the formation of groups to listen to, and discuss the recordings.[6]

3. Several mental hospitals hold clinical meetings or case conferences to which the local general practitioners are invited.

There is a flourishing psychiatric discussion group, meeting at St. John's Hospital, Stone, near Aylesbury, at monthly intervals. About 20 to 25 general practitioners take part and the meetings alternate between discussion of a case presented by one of the members, and a lecture given by one of the psychiatrists. Films or recordings from the medical recording service of the College of General Practitioners also form subjects for the meetings, which have been held since early in 1960.

Occasionally, symposia are organized by the College of General Practitioners or other bodies.

4. Many general practitioners have an excellent liaison with the psychiatrist by means of domiciliary, telephone, or other consultation, and by discussing his patients in this way with the psychiatrist, the general practitioner learns how to treat them more effectively.

5. In some hospitals the general practitioner may work as a clinical assistant, paid or unpaid, to the psychiatric department. Since 1954, there has been a general practitioner working as clinical assistant in the psychiatric department at Oldham. This arrangement has been found to be a very valuable link between the psychiatric services and the local general practitioners. The general-practitioner clinical assistant is in a position to explain to the psychiatrist the general practitioner viewpoint and *vice versa*. Further, through his close contact with the psychiatrists, the clinical assistant receives training and experience in understanding and treating psychiatric illness.

6. The general practitioner who wishes to enlarge his knowledge of psychological medicine and also to learn how to apply this knowledge in his practice of medicine may choose to participate in a training group seminar, meeting regularly for case discussion over a long period.

It is with this method that this paper is chiefly concerned.

Whilst all the methods outlined above are valuable to the family doctor in gaining postgraduate education in psychological medicine, and many doctors make use of some or all of them, I believe that the training groups have something distinctive to offer in this field, and that they differ significantly in their aims and results from the other methods. It is my intention to discuss these groups, their aims and their methods, their similarities and their differences, and to note in particular their common desirable characteristics, establishing some criteria for the ideal group, with a view to the institution of further groups in other parts of the country.

History

The idea to use groups as a method of training in psychological medicine developed out of the Hungarian system of training analysts. The Tavistock Clinic pioneered in this field with the establishment of training groups for social workers, and in 1950 it was decided to extend this method to general practitioners. Seminars were established to " study the psychological implications in general practice, to train general practitioners in this work, and to devise a method for such training ".[7]

There are at present nine groups meeting at the Tavistock Clinic and three at the Cassel Hospital for Nervous Disorders. There is a group at the Marlborough Day Hospital, St. John's Wood. A group meets at the Maidstone Day Hospital, and another has recently started at Canterbury. Groups meet at Ipswich, Leeds, and Sheffield. There are two groups meeting at Plymouth. A similar, though shorter approach is used at Rubery Hill Hospital in Birmingham, while also at Birmingham, at the Uffculme Clinic, an official postgraduate course extended over six weeks has used this method. There has also been a group at Worthing.

This method of training has spread to the Netherlands, to Germany, and to the U.S.A. Groups for workers in other fields have also been initiated, including industrial medical officers, probation officers, prison officers, and clergy.

The Aims of the Training Group

The aims of the original Tavistock Clinic groups have already been stated.

The aims of other groups are variously stated as:—

(i) To study the doctor-patient relationship in general practice.
(ii) To learn to treat neurosis at general practitioner level.
(iii) To learn to apply psychotherapy in general practice.

Discussion of individual cases forms the basis of the study. Usually one of the group presents a case history, occasionally tape

recordings of interviews are played, or a patient may attend in person. Case histories may be followed up over a considerable time. Attention is focussed on the " here and now " situation between the patient and the doctor, how the patient presents and how the doctor reacts. The doctor is enabled to gain insight into his role in the relationship, and with the support of the group he is enabled to treat successfully by psychotherapy patients whom he would have previously referred to the psychiatrist or treated by other means. Furthermore, all the members of the group learn from each other how to use themselves more effectively and selectively.

The treatment of neurosis is largely a general practitioner problem, and neurotic illness constitutes the bulk of the case material discussed at meetings. The general practitioner, being easily accessible to the patient, is in a key position to carry out early treatment of emotional disorders, and whether he faces up to it or not, he is frequently required to practise psychotherapy in one form or another.[8] This, indeed, may amount to a quarter or one third of his treatment,[7] and in one survey accounts for 53.9 per cent of treatment given.[9]

The family doctor needs to learn to use himself, to apply psychotherapy, to exercise his bedside manner, with the same degree of insight and skill as he at present uses his diagnostic instruments and drugs.

The three aims as stated above are complementary, and the first is fundamental to the other two. Learning to use psychotherapy involves learning about one's own emotional blind-spots and limitations. In learning to treat neurosis in a general practice setting the doctor learns to use psychotherapy. In studying the " here and now " situation existing between the doctor and patient, the doctor-patient relationship is being studied and understood.

A description of Several Training Groups

The Tavistock Clinic.

The history and aims of these groups have already been noted. New groups are advertised in the medical journals. Prospective members are first interviewed. The majority of applicants are accepted but those who are rejected include:—

(i) Those who are primarily seeking therapy for themselves
(ii) Those who " do " a postgraduate course every year and know all the answers
(iii) Those who are excessively demanding of themselves in their work
(iv) Those who are looking only for direct teaching, advice, and support

In other words, the neurotic, the know-all, the too rigid, and the too dependent. Membership is confined to general practitioners,

although doctors in other disciplines may be present as observers.

The size of the group is usually limited to ten general practitioners; a fall-out rate of two per group is expected. Meetings take place at weekly intervals, in an afternoon, and last $1\frac{3}{4}$ to 2 hours. Case presentation by the members and discussion around them forms the basis of the study.

Initially, new groups try hard to involve the psychiatrist in a pupil-teacher relationship, but didactic methods are kept to a minimum. The emphasis is on examining and evaluating the "here and now" situation between the doctor and patient, the doctor being free to accept or reject the group's suggestions on the handling of the situation. All the leaders are analytically trained and have considerable experience of group work. Meetings are recorded on tape.

Each group has a life of 4 years. It is reckoned that 2 years must be allowed for unlearning established patterns of reaction and prejudice before the member will begin to accept criticism, and a further 2 years must be spent acquiring insight. The acquisition of insight, that is of learning about one's own blind-spots and limitations may, and often does, cause an unpleasant strain, and it is the task of the group leader to create an atmosphere in which each member will be able to bear the strain.

General practitioners attend, or have attended, from towns as distant as Southampton, Bournemouth, Leicester, and Nottingham, though the majority of the members come from the Metropolitan area. They remain family doctors and do not become "amateur psychiatrists". A general practitioner who forsakes his work to specialize in psychiatry is counted as a failure from the training standpoint.

The Cassel Hospital, Ham Common

The aim of the group is to help the general practitioner to gain insight into handling emotional problems as they arise in his practice, and thereby to do his work better, and not to become an inferior type of psychiatrist.

The first group was formed in 1956. All doctors on local executive council lists were circulated. A second group was formed in 1958. At present, there are three groups operating, one of which incorporates the two original groups. The last group was advertised in the medical press.

Applicants are at first interviewed to ascertain that they are actively engaged in general practice. Originally, an age limit of 45 was fixed, which was subsequently raised to 50. No difference in

the ability of older doctors to settle into the group was noted.

There are ten members in each group. Of the ten members of the original group three fell out. A fall-out of two or three is expected. Meetings are held weekly, in an afternoon, throughout the year, with the exception of the psychiatrist's holidays.

Case presentation is the method of study, and emphasis is on the behaviour of the doctor rather than of the patient. The psychiatrists leading the groups are analytically trained, and have sat in on training groups at the Tavistock Clinic, and in addition are experienced in group therapy. They hold such pre-training is essential. They regard the training of their junior psychiatrists in the handling of general practitioner groups as a routine step towards their function as psychiatrists. Notes of the meeting are taken by a stenographer. They are then edited and circulated to the members. The original group consists of doctors who have been attending for 5 or 3 years. About 40 cases are discussed every year. It is apparent to the leader that the members have aquired insight into their understanding of patients, by working through their own problems in relation to the patients'. It was apparent also that it took 2 years for members to accept criticism of their handling of patients.

The Marlborough Day Hospital, St. John's Wood.

Groups have been held at this hospital since 1946; although primarily intended for general practitioners, membership does not appear to be limited to those actively engaged in general practice.

Meetings take place weekly in an afternoon, and last 2 hours. The method of study includes the analysis of the doctor-patient relationship through the analysis of cases presented by the members. In addition, patients are demonstrated in person by the leader of the group, and the members feel that this is a most valuable part of the course. Some are of the opinion that the presence of the patient is essential for the teaching purposes as only by seeing the psychiatrist and the patient in an active relationship can they learn to handle a situation in any eventuality. When they have not a patient to present, members are encouraged to discuss their own personal problems. They are also encouraged to have a personal analysis. In addition, they are enabled to work as unpaid clinical assistants at the hospital. Furthermore, there are three paid posts for general practitioners, one of three sessions at senior house officer grade, one of three sessions at registrar grade, and one evening session in relation to a therapeutic social club.

Whilst one or two general practitioners attending the courses have gone into full-time psychiatry, the majority have remained in general practice with a very much better understanding of their patients.

The Maidstone Day Hospital.

The aim of the group is to enable general practitioners to study psychotherapy. It came into being in 1958. It is an open group, that is, it collects new members as time goes on, instead of running a limited course with a pre-determined membership.

Membership is confined to general practitioners; about 18 in all come to the meetings, the average attendance being around 12. The members come from mixed and rural practices in the Mid-Kent area, over a thirty-mile radius, and considerable social contact has developed as a result of the group meetings.

For the first eighteen months meetings were held at weekly intervals, now they are held once a fortnight. They take place in the evening, over tea and sandwiches and last about 2 hours.

Case presentation and discussion form the basis of the study. The leadership is passive, direct teaching and advice being given only seldom by the psychiatrist. The group themselves make suggestions as to the best line to take in treatment and thus arrive at the most acceptable solution. The leader rarely interprets the behaviour of the members; the risk of the breakdown following a too forceful interpretation cannot be discounted and such traumatic situations must be avoided. The interpretation may come from another member of the group, and the psychiatrist needs to be on his guard to spot too traumatic situations developing and to squash them.

At the group meeting which I attended, the presentation of the cases and the discussion which followed indicated that the members had reached a high standard of competence in handling emotional disorders in general practice. The members have noticed a considerable change in their approach to emotional problems since attending the group meetings. One doctor felt that there was a danger of becoming too involved with the patient but that if one did one had the group in support.

Dr Hyatt Williams, the leader, has over the past 3 years noticed a real change in the group. At first he had to resist the pressure of the group to get him to lecture to them. Persons other than himself have noticed personal maturation in the members of the group and Dr Hyatt Williams has also noticed a tremendous increase in skill and confidence in the handling of the mild psychotherapeutic problems in general practice.

(A new development has been reported by Dr Hyatt Williams since the original survey was carried out. The group felt that they had gone about as far as they could according to their original terms of reference, and the nucleus of the group, about nine in all decided to

continue with altered technique in which the psychiatrist intends to interpret the behaviour of members, in particular in relationship to their own patients.)

Dr Hyatt Williams had also initiated a general-practitioner group in another area, but this group failed to establish itself and, having remained didactic for 6 months, discontinued. The reason for its failure to mature was probably owing to the competitive private practice in which its members were engaged, they were reluctant to admit their mistakes to each other.

Canterbury

A seminar in psychotherapy for general practitioners was instituted in February 1961 by Dr H. J. Hambling, at the request of several family doctors who had read about the Tavistock Clinic experiment. All the doctors were circulated through the British Medical Association. No selection was made, and the present group is entirely self-selected. About 12 practitioners meet informally every fortnight over coffee and beer, for about 2 hours. Spontaneous discussion of topics raised by the practitioners from their practice is the method of study. Minimal anxiety was expressed by the non-directive and non-pedagogic attitude of the convener, who had felt that the group would organize around its needs once he had overcome their deference to the expected teacher-pupil relationship.

At first, discussion centred around relations with consultants, and had a lot to do with getting the measure and sympathies of the convenor. Thus satisfied, the members turned to the topic of discussing patients and of asking for help from the group in these discussions. The doctors seemed more concerned with each others attitudes than with the nature of the patient's problems. They have proved able to accept quite a lot of good natured and shrewd criticism from each other. They were more on the ball about their own attitudes than they were on motivations of patients, bearing out the need for doctors to acquire insight into themselves and thus improve their techniques in handling patients.

Now that some confidence is felt in the ability of the group to see the doctors through difficulty, some members are gingerly undertaking psychotherapy as part of their total approach. The self-selection has proved satisfactory and no unresolvable tensions have arisen. If at any time a demonstration on a patient is wanted or they want a formal approach to a psychiatric subject, this can be given by another consultant.

In the group, Dr Hambling is endeavouring to keep direct teaching and advice to a minimum. The group was started as an experiment to last one year, and on present form it should last longer.

Ipswich

The proceedings of the Ipswich group have been fully reported in the *Journal of the College of General Practitioners.*[10]

The aim of the group was to some extent experimental. Its target was to find means by which the members could better deal with patients whose symptoms were produced by emotional factors.

The group was formed in 1957. Members were selected from the replies of general practitioners to a circular, on the personal knowledge of the psychiatrist. Four men and two women were thus selected, five in general practice and one working for the Family Planning Association. This doctor has since become clinical assistant in psychotherapy to a consultant physician.

One of two partners in the group dropped out shortly after its inception, owing to the difficulty of both being away from the practice at the same time. The choice was made by lot. After a year, as the group felt that it was becoming somewhat esoteric, two new members were invited to join. One unfortunately soon felt unable to continue, the other, a lady member, is working for the Family Planning Association. One other member left owing to taking up a clinical assistantship in psychiatry elsewhere.

Meetings were held fortnightly except during the school holidays. They lasted two hours, although informal discussion sometimes continued after the meeting had ended.

Initially, the psychiatrist gave considerable direction on psychiatric history taking, on the various patterns of stress, and on psychological interview. Subsequently, case discussion became more prominent, although other topics relevant to general practice, including the perennial problem of finding the time for interview, appointment schemes, and note taking were also discussed.

The pattern has been to discuss only a very few patients, but these have been studied in considerable detail and followed up over a long period of time. A few cases studied in this way was felt by the group to be of more value than many cases studied more superficially. In gaining insight into the patient's problems it was found that the doctor gained insight into his own, an experience that could be traumatic, as the personal factor entered into the group discussion.

There was a phase at the end of the first year when the impetus seemed to lag, but when this passed, discussions took a deeper and more valuable turn. The members feel that they have gained much in diagnostic ability and in insight, both of themselves and of the patients. They find that they carry out their work with deeper vision.

After three years, the group felt that it had fulfilled its original

aims, and formal meetings were discontinued although the members intended to meet from time to time informally.

When this group was formed none of those participating had read *The doctor, his patient, and the illness* and they agreed not to read it; yet the development of the group bears a considerable similarity to those groups owing their origin either directly or indirectly to the Tavistock Clinic.

Leeds

The aim of the group is to help doctors to learn to use the doctor-patient relationship more effectively. Strictly speaking, the group does not study psychological medicine though it is continuously concerned with the handling of psychiatric problems.

The group was initiated by Dr R. E. D. Markillie in 1958. A circular was sent through the Leeds, Bradford, and North Riding Executive Councils to all doctors on their lists. Forty-five doctors replied, and ten were selected at interview. Whilst those obviously unsuitable on account of their own psychopathology were turned down, the necessary limitation of the size of the group still left an unsatisfied demand, and Dr Markillie hopes to start shortly a group meeting at Bradford.

Initially, the doctors attending were all in the 45 to 55 age group; about 18 months ago four younger doctors were introduced and the group has remained closed since. Two members dropped out, one because of the distance. About eight doctors attend each meeting, held at weekly intervals in the afternoon, except for holidays. All the members are engaged in active general practice. The meetings centre around case presentation, teaching is given where it is specifically indicated.

Dr Markillie had experience of groups at the Tavistock Clinic before coming to Leeds. He is of the opinion that group experience is essential for the leader as without it he may not know in which direction either he or the group is going. He felt that it was doubtful if a group could run on its own without a leader; it would be in danger of being dominated and controlled by its most disturbed members. Dr Markillie has refrained from interpreting to the members their behaviour; they in their turn have tended to be very polite in their criticism of each other. Dr Markillie feels that this is a disadvantage inherent in a provincial group, where the doctors tend to know each other socially.

Members of the group however make these comments; they are prescribing less often and less automatically, they do not feel that they have to give the patient something, they are referring less, and more selectively, to consultants.

None of the group have been converted to full-time psychiatry, none are even clinical assistants. Dr Markillie would consider that the group had failed in its object if a general practitioner did change. The whole object of the group is to help the general practitioner to become a more effective general practitioner.

Sheffield

The group studies psychological problems in general practice.

It was formed in the summer of 1960, after general practitioners in the Sheffield area, meeting Dr W. Lawton Tonge on domiciliary consultations, had asked him to form a group. Dr Tonge had previously run a group at Cheadle.

The group was self-selected in reply to a circular sent out to all general practitioners in the Sheffield area. About a dozen general practitioners come to the meetings, which are held once a fortnight, and the average attendance is around six or seven. The age limit of the group is 35 to 40.

There is little formal teaching unless the group specifically ask for this on some aspect of psychiatry. Case discussion forms the basis of the meetings. This tends to remain on the diagnostic or general treatment level, as the members on the whole have not got the time or the desire to embark on psychotherapy. There is very little in the way of criticism of each other in the way they handle cases. It is the group itself which has decided to be run in this way. The group requires two things from its leader:

(i) support and reassurance in their handling of cases
(ii) advice about the correct attitude to their patients.

The Rubery Hill Hospital, Birmingham

The aim of the seminars is to enable general practitioners to study emotional disorders in general practice.

Dr Mathers, Medical Superintendent of the Rubery Hill Hospital, began the scheme in June 1960 as a means of making contact with the general practitioners in the catchment area of the hospital. They were notified of the meetings through the local branch of the British Medical Association, and 17 doctors in all have attended three groups. One group had only two members, but the others had six to eight members.

It has been noted that disturbed doctors apply for self-therapy, but in view of the small numbers applying there has been no selection by interview.

Meetings are held at weekly intervals, either in an afternoon or evening and last about 2 hours. Members of the groups are per-

suaded to discuss their own patients, and there is no direct teaching unless it is expressly indicated.

Both Dr Mathers and Dr Yerburgh who also takes a group have experience of working with therapeutic groups. They feel that it is essential for any potential leader to have such experience, in order that he can spot traumatic situations arising in the group and handle them before they become too intense. It may, however, be necessary for the individual member to feel uncomfortable before he can mature, or gain insight.

One general practitioner with considerable ability in psychological medicine is now a clinical assistant at the hospital.

Each course has lasted only 10 weeks. This has been dictated largely by the commitments of the medical staff. While agreeing that ten sessions is not as long as the ideal, Dr Mather feels that it is better than nothing at all. There is value in sowing the seed and allowing it to germinate. In fact, doctors are re-applying for subsequent courses. It is proposed to continue courses along these lines.

The Uffculme Clinic, Birmingham

The Clinic has held annually for the last 5 years two weekend courses for general practitioners, and from the doctors attending these courses has arisen the request for a longer course. The Uffculme Clinic was asked by the postgraduate dean to run a series of seminars.

When the course was advertised, 90 doctors replied, from up to 50 miles away. It was decided to limit the numbers to 20 in each group and to hold two groups. The average attendance at each session was about 16. Meetings were held on one afternoon a week for 6 weeks, and lasted 2 hours.

One group was led by the late Dr Mayer-Grose, the other by Dr J. A. Harrington. The pattern that the meetings took was largely determined by the psychiatrist; Dr Mayer-Grose used a directive and didactic technique, Dr Harrington used non-ductive free discussion, especially around case presentation. One of the features of this group was the playing on tape of a passive therapeutic interview conducted by Dr Harrington.

This training group differs from the others in that it was officially sponsored by the Postgraduate Medical Federation. It was limited to six sessions. This was partly dictated by the P.G.M.F. and partly by staff commitments. It is intended to repeat these courses annually.

Plymouth

The aim of the group is to learn how to treat neurosis at a general

practitioner level. This includes studying the relationship of the patient to his illness, and the relationship between the doctor and his patient.

The group was formed in 1958 on the initiative of a general practitioner, Dr Hamlyn, who asked Dr Blair, consultant psychiatrist to Moorhaven Hospital, to take a group along Tavistock Clinic lines. The group was selected by personal invitation of general practitioners known to Dr Blair or Dr Hamlyn. At the outset there were twelve general practitioners in the group, a thirteenth joined in February 1959. About eight general practitioners attended each session, which were held weekly in an evening during the six winter months, over beer, and lasted 2 to 2½ hours. After the first year two members dropped out. During the second year, owing to Dr Blair's unavoidable absence, the group was led for several sessions by Dr K. F. Weeks.

The meetings are built round case presentation and discussion of cases and topics arising therefrom. Members gave their opinions on the diagnosis and management of the case and the doctor was free to accept and reject their advice. There was quite free criticism of the way in which cases were handled. The leader would usually sum up each case after the discussion, offering his own opinion and advice, and direct teaching where it was expressly indicated.

A large number of patients, 73, were discussed during the first two years. While this tallies with the Cassel Hospital's average of 36 per year, it is far in excess of the six cases discussed annually by the Ipswich group. However, in the first instance it was felt desirable to cover as wide a range of psychopathology as possible. Printed minutes were circulated to all the members after each meeting; these also provided the vehicle for direct teaching on psychodynamics and psychopathology, which was not a prominent feature of the actual group discussion. Books were also recommended from time to time, and members also played tape-recordings of interviews which they had conducted.

In the autumn of 1960, as there was a demand for a second group, Dr Blair sent out a circular through the local executive councils, to which 25 doctors replied, about 12 of whom attend each meeting. The meetings take the same form as the first group, but are held fortnightly. On one occasion a patient has been presented in person.

Four members of the original group continued to meet, without a psychiatrist owing to the demand of the second group. After some time, it was noted by Dr Weeks that the printed minutes revealed that each member was becoming rather fixed in his choice and presentation of case material. Two psychiatric registrars, who had

expressed a desire for further training in psychotherapy, joined the group, which has continued to meet to the mutual advantage of both psychiatrists and general practitioners.

Worthing

Following the introduction of the Day Hospital Scheme at Worthing in 1957, a request was made by a number of interested general practitioners for a course in psychotherapy.

Dr Olive Inman agreed to take a training group and an invitation to discuss the project was sent to every general practitioner in the district. Ten attended the preliminary meeting in May 1958 and altogether about eight doctors attended the group meetings. These were held on one afternoon a week, for 2 years, and lasted about 1½ hours. Tea was provided. There were some changes in membership owing to removals.

The principal objects of the group training were:—

(i) To develop a more understanding and tolerant attitude to the frankly neurotic patient and his problems.

(ii) To explore emotional factors in all kinds of ill-health and ill-behaviour in the *not* obviously neurotic.

During the first year, two or three urgent new cases would be reported at each session in addition to follow-up reports. At that time, first-aid seemed more important than major surgery. In the second year a deeper study was undertaken of fewer cases, and the number of childhood disorders rose from 18 per cent to 60 per cent of the case material. As the group came to realize that morbid emotional and somatic patterns may still be reversible in these formative years, the general practitioner's opportunities in the field of preventive medicine and psychiatry came under consideration.

Dr Inman's leadership, after an introductory talk, remained largely passive until appealed to for comment. Although she rarely made interpretations of members' attitudes, there was a clearly marked process of change going on towards self-knowledge, and more sympathetic insight into the inner lives of other people. Dr Inman had both training in psycho-analysis and experience in general practice. During the first year the sessions were recorded on tape and Dr Inman also kept brief notes.

Doctors attending the course made the following comments about it:—

(i) These discussions in psychiatry have opened up a new field of medicine to me.

(ii) The discussions arising out of his own and other doctors' cases are of great benefit, and can certainly add skill to awareness and enthusiasm towards psychotherapy in daily practice.

(iii) Patients who have been a pain in the neck to me have now become a source of interest.

(iv) Learning about others one learns a lot about oneself; in the process one's whole attitude to many things may change.

(v) The session is the highlight of the week.

Discussion

It is noteworthy that five of the twelve groups described, originated at the instigation, or in response to the demands, of general practitioners, and that these five groups comprise more than half of the groups started since 1958. It is also of note that there was originally an unsatisfied demand for this type of training when it was instituted at Leeds, and this trend is borne out by the recent survey of postgraduate education carried out by the College of General Practitioners, mentioned earlier.[5] The motivation to form the other groups had come from the psychiatrists for reasons which include research, apostolic function, the desire to establish better relationships with the general practitioners, and probably also, stimulation by other groups.

Advertisement

Groups have been advertised through the medical press, by circular through the B.M.A. or executive councils, and in one instance through the P.G.M.F.

Selection

The number of applicants rejected depends largely on the numbers applying, all being accepted where the numbers are small, as at Rubery Hill. The small demand so far here is thought to be due largely to the proximity of this hospital to the Uffculme Clinic. Where selection applies, it is by interview or by personal invitation. The purpose of selection is to ensure that doctors applying for the course are actively engaged in general practice, and that they are applying for training and not for therapy.

Attendances

Figures for these vary from two to 16. Two is considered by the psychiatrist who led them to be too small. Apart from these two figures attendances vary from four to twelve, eight to ten being the commonest figures. Two or three drop out of the group during the first year.

Frequency of meetings and duration of course

In all groups, meetings are held at weekly or fortnightly intervals,

more commonly at weekly intervals during the initial year or 18 months. Some groups stopped meeting for holidays, one, at Plymouth, had a close season during the summer. This period was found useful for reading and assimilation. The meetings lasted from 1½ to 2½ hours, and at some groups refreshments were taken. Nine of the twelve groups have a life of one year or more, two ran for only 6 weeks and 10 weeks, and another has been running for less than a year, but is planned to go on for at least a year. One group has been meeting for 5 years, and a life of 4 years is considered necessary by the Tavistock Clinic, who have largely set the pattern for this type of study.

Methods of study

In all groups described the common feature is the presentation and discussion of cases being treated by the members. One group felt it was preferable to have the patient present, and interviews between the psychiatrist and a patient are a feature considered helpful by the members. One other group has been given a demonstration with a patient present. At another group a tape-recording of the psychiatrist conducting a passive therapeutic interview was considered valuable. Tape-recordings of interviews by the members have been found valuable by another group, in enabling the group to study more effectively the role and behaviour of the doctor in the therapeutic interview.

In nine of the 12 groups, an inherent part of the training is the acquisition by the doctor of insight into his role in the doctor-patient elationship. This is achieved through the examination of the doctor's behaviour in the doctor-patient relationship, by criticism and interpretation, and by evaluation of the "here-and-now" situation. It is for this reason that case presentation by the members is the most important topic of study. Other topics relevant to general practice and psychodynamics may be discussed. The members of one group of the nine are in addition encouraged to have a personal analysis.

Some groups have found it useful to circulate printed records of the meetings, taken by the leader, or the members in rotation, or a stenographer, or recorded on tape.

Leadership

The behaviour of the leader is of paramount importance as he determines and controls the direction in which and the degree to which the group will develop.

Teaching:—The immature group will seek to perpetuate the pupil-teacher relationship acquired in their student days; they will show a tendency to get the leader to lecture to them, and this must be resisted

by the leader. This raises difficulties in the need to teach the theory of general psychiatry, while at the same time avoiding the error of being too didactic, the whole set in a framework of discussing the management of cases having psychotherapy. The leader can interpolate direct teaching at a point where it appears to be expressly indicated, or the initial sessions can be devoted to the teaching and discussion of general principles in psychiatry, or teaching in specific subjects can be circulated to the group in form of printed matter. The leader may suggest suitable reading. Interview technique may be demonstrated with a patient present or by tape recordings.

But principally the member must learn to listen to the patient and allow him to talk; consequently, the leader must set a pattern of listening to the members and allowing them to talk.

Reassurance and support:—The immature group will also expect to get reassurance and support from their leader. While this may be indicated in certain circumstances, continuous exhibition of this will leave the members dependent on the leader, whereas the members should be enabled to mature in their ability to handle the doctor-patient situations. Therefore the members must be allowed to " burn their fingers " handling situations in their own way. It is important for the leader to get to know the members of the group, their potentialities and their limitations; thus he is able to stop them from taking on cases beyond their ability, while encouraging them to continue to tackle cases within their capacity. This is of particular value where the groups are drawn from the catchment area of the psychiatrist's unit, as he is able to build up a team of general practitioners whose abilities are known to him.

Criticism and interpretation:—The leader from time to time interprets to members their behaviour. Too early or too forceful interpretation may result in members leaving the group. Members may criticise each other, and the leader must prevent this from becoming too forceful or traumatic. As the group continues to mature, the ability to receive and to give criticism will increase. The group continues to mature as long as it can face the strain of acquiring insight.[7]

Some psychiatrists feel that they may have been too passive in the matter of interpretation and criticism; nevertheless, comments from the members indicate that they have gained insight.

Training:—Generally some experience in handling therapeutic groups is considered desirable for potential leaders. Analytic training is not a necessity but several leaders have had the experience of sitting in on training groups.

Is the leader necessary? The leader is necessary to:

(i) Control the development of the group, giving instruction, advice and support where required, but not to excess;

(ii) Establish a passive, receptive relationship with the members, thus enabling them to exhibit the same attitude in the therapeutic relationship;

(iii) Interpret and criticise the behaviour of members where indicated;

(iv) Control interpretation and criticism between members, and prevent too traumatic situations developing.

Without a leader, a group would be in danger of being dominated and controlled by the most overpowering members. There may well be a demand for training groups in areas where psychiatrists are unwilling or unable to take them. The staff of the Tavistock Clinic and the Cassel Hospital are prepared to travel to other parts of the country to lead groups, and already go to Holland for this purpose.

Criticism of the training group method

During the period of investigation, I encountered several criticisms of this approach to the study of psychiatry in general practice.

1. The good general practitioner uses common sense anyway. While there are, without doubt, general practitioners who intuitively use themselves to their fullest advantage, even the wisest have emotional blind spots which participation in a group would help them to recognize and possibly remedy.[8] It is better to use even common sense with insight, than to use it empirically.

2. The group is primarily therapeutic.

This is a danger inherent in this type of work. It has been noted that disturbed doctors apply in order to get therapy for themselves. For this reason, some groups insist on an initial interview to exclude obviously unsuitable applicants. In only one group are the members encouraged to discuss their own personal problems and to undergo a personal analysis.

3. That participation in a group may be emotionally traumatic for the members.

This is also recognized as an inherent risk in this work, and indeed one psychiatrist remarked that members must feel uncomfortable to mature, and another group averred that the personal factor entering into group discussion could be a traumatic experience for the individual concerned.[10] Providing that the psychiatrist is not too enthusiastic in interpreting members' behaviour early in the life of the group, and is alive to the development of traumatic situations in inter-member relationships, this need not be considered a risk. Traumatic situations between members are probably more likely to arise in an open group, where new members,

either less or more sophisticated are introduced from time to time, than in a closed group, in which the members growing up together as it were come naturally to accept each others' criticisms.

4. That the group is turning general practitioners into psychiatrists. The Tavistock Clinic considers that a general practitioner who gives up his work to go in for psychiatry is a failure from the group point of view.

Dr Main at the Cassel Hospital considers that the object of group training is to help the general practitioner to do his own work better, not to become an inferior type of psychiatrist.

Dr Bierer of the Marlborough Day Hospital writes that " whilst one or two have become full time psychiatrists the majority have remained in general practice with a very much better understanding of their patients."

Dr Markillie at Leeds states that the whole object of the group is to make the general practitioner a more effective general practitioner. None of his group have changed to full-time psychiatry, and he would consider any who did so as failures.

5. That psychotherapy is too dangerous a procedure for general practitioners to use.

Any drug in the pharmacopoeia is dangerous if used without knowledge of its potentialities. Psychotherapy attempted without insight is equally dangerous.

> The bulk of straight forward psychotherapy is already done in general practice and this is likely to continue to the betterment of general practice and psychiatry . . . the general practitioner has to practise psychotherapy in one form or another whether he likes it or not. The problem is to make this form of treatment more effective and more widely applied.[8]

The group teaches the doctor to use psychotherapy with insight.

6. The general practitioner with a full list has no time for psychotherapy anyway.

Lack of time is not an adequate reason for withholding from the patient the treatment of choice. If the general practitioner " has no time" for psychotherapy, then he must consider whether his list is over full, or whether he is misusing his time. Granted, psychotherapy can be a time consuming procedure. Yet it is within the scope of a busy general practitioner's work. The author has a list of 2,500 patients, and sets aside one evening a week, in which he is able to give three or four insight-giving therapeutic sessions. Supportive psychotherapy can be given in normal surgery time. There is indeed a danger that the busy general practitioner may lose the art of listening. He may be careful and troubled about many things, but one thing is most needful.

7. The group may tend to become esoteric and narcisstic.

This danger was sensed by the Ipswich group, who felt after a year they had become rather unified and invited in two new members, one of whom soon felt unable to continue. The Leeds group introduced four new members after 18 months. In point of fact, as long as the group is aware of the danger of this occurring it is unlikely to happen. I have had the experience of sitting in on two groups at the Tavistock Clinic, and the Maidstone Group. In addition, Dr Balint and members of the Tavistock Clinic group joined in a seminar with the Plymouth group. The similarity of viewpoint in all these meetings was very apparent. One would expect esoteric groups to deviate progressively from the norm.

8. Attendance at a training group is a time consuming procedure.

9. Doctors are unable to attend during peak periods of work.

In none of the groups visited did these factors present any serious obstacle to attendance, many doctors travelling considerable distances to attend meetings.

Disadvantages inherent in the group seminar method

1. With the exception of the Uffculme Clinic, none of the groups are recognized as postgraduate courses by the Postgraduate Medical Fellowship. Doctors attending, sometimes from considerable distance, have to cover the cost of their travel.

2. Some are not recognized by the Regional Hospital Boards as sessions. The psychiatrists give their time voluntarily.

The effects and advantages of the training group method

The training group differs significantly from formal postgraduate courses, in that learning is allied to practical experience of one's own cases and those of other members. Furthermore, in the traditional postgraduate course the general practitioner is taught what the specialist thinks he ought to know, and the teacher-pupil relationship of student days is preserved. In the training group there is a new emphasis and a new discipline. Whilst not in any way decrying the value of the formal postgraduate course, nevertheless the doctor attending a formal course is in danger of being as the man who, beholding his own face in a glass, went away and straightway forgot what manner of man he was. In the training group, one is learning in the context of one's own experiences and the environment of one's own practice, and one is not allowed to forget, or at least it is less easy to.

In addition to learning psychological medicine, psychodynamics and psychotherapy as applied to general practice, the member in discussing and gaining insight into the problems presented by his

patients, gains insight into his own.[10] We all have our emotional blind spots and we must be aware of these, and how they affect our handling of patients, to be all-round psychotherapists.[8] Further to acquiring insight into his own behaviour in the doctor-patient relationship, the doctor, through criticism and examination by others, learns afresh to re-examine himself and to take a more objective view of his own feelings and actions. General practitioners, by reason of their isolated position in the medical community, can only too easily become entrenched in complacency.

There is also the supportive function of the group, members treating successfully with the support of the group, patients they would otherwise have avoided, mishandled, or referred to a psychiatrist. In this respect, it is a comfort for the general practitioner members of the group to learn that even psychiatrists are not omnipotent.

The training group method of study with its emphasis on the patient who has the disease rather than on the disease, opens up a holistic field of medicine to the doctor conditioned to looking for disease entities. Doctors, depressed or disillusioned by the number of patients they are apparently powerless to help because they have not been taught to understand them, find new opportunities to treat and to prevent emotional ill health, widening the scope of their general practice. In learning to use himself more effectively in the psychotherapeutic relationship, the doctor learns to use himself more adequately in all aspects of the doctor-patient relationship.

Finally, where the members of the group are drawn from the catchment area of the psychiatrist's unit, co-operation between the mental health services and the general practitioner is promoted to the betterment of the community as a whole.

Variations on the group scheme

Private groups.

Graves and Graves mention the forming of groups to listen to and discuss recordings from the Medical Recording Service of the College of General Practitioners. They have collected figures of the attendance at each playing of each recording since the inception of the scheme. Recent figures suggest a divergence between groups of friends who meet informally to listen and regular study groups meeting specially for the purpose, which do not solely meet now to listen to the recordings but which meet also for case discussion and talks from consultants.[6]

Groups within a practice.

Several group meetings occur within the framework of the

Edinburgh University General Practice Training Unit. These include:—

1. Daily conferences with all the staff, including social workers and students, lasting one hour, at which all the aspects of the day's case work is discussed and questioned. These meetings are sometimes recorded on tape. In this way the permanent staff gain considerable insight into their own attitudes, while the students are introduced to the critical approach of group training.

2. Weekly tutorials of the same nature, attended by the teaching general practitioners and the students attached to them.

3. Weekly meetings of the same nature between the health visitors and the medical staff.

4. Meetings are held once very 3 weeks of the same nature as the daily conference but with a psychiatrist in attendance, thereby approaching more nearly to the organization of the training group.

At the Darbishire House Health Centre at Manchester, informal meetings are held each morning over coffee, attended by the general practitioners, the Reader in Social Medicine at Manchester University, the social worker and the students, which serves the same purpose as the daily conference at the E.U.G.P.T.U.

Group practices and partnerships might well consider adapting this type of conference to their own use, with benefit both of increase in personal insight and modification of approach to all participating.

Summary and Conclusions

There is a need for postgraduate training in psychological medicine for the general practitioner. Methods of training have been outlined and the training group method described in detail. It is not claimed that the training group method supersedes the other types of training. Indeed, the general practitioner would do well to avail himself of all the facilities in this field. The training group method does however have certain characteristics, which have been discussed, which make it a particularly suitable method for training general practitioners not only in psychiatric techniques, but also to become more accomplished general practitioners. There are good grounds for making these courses official and more widespread.

It is my opinion as a result of this survey that the ideal group should have the following characteristics.

It should be formed by circulating all the doctors in the catchment area of the mental hospital or psychiatric unit through the local executive council or B.M.A.

An attendance of eight to ten at each session should be aimed at, and a fall-out of two to three members in the first year expected. This should entail an initial membership of twelve to fifteen. Doctors applying for therapy rather than training should be eliminated where possible by a preliminary interview.

Meetings should be held at weekly or fortnightly intervals, and

last about two hours.

The meetings should centre around discussion of cases presented by the members.

The leader should have experience with psychotherapeutic groups and possibly previous experience of training groups. He should resist the initial pressure of the group to get him to lecture to them, encouraging the members of the group to make their own decisions about their cases, accepting or rejecting the advice and criticism offered by other members. Whilst attempting to lead the members into increased understanding of their own limitations, he should be aware of the trauma inherent in the acquisition of insight, and alive to the tensions developing in the group. Although he should probably interpret too little rather than too much, the group should mature and the resultant change in individuals would not only be apparent to themselves but also to others. The principal change should be a new appreciation of the emotional factors operating in illness as seen in general practice and the acquisition of skill in handling emotional problems. The general practitioner should develop a more holistic view of the patient and his illness, resulting in a new interest in general practice.

The group should continue to meet for a minimum of 2 years, and the members should extend the influence of their group training to a wider field by initiating discussion in the framework of the group practice or partnership or in discussion groups with fellow general practitioners.

In conclusion, there may be, or may have been, training groups of whom I am unaware, and have therefore omitted to mention. If so I apologise to them, and should be grateful to learn of their experience.

Acknowledgments

I should like to thank the College of General Practitioners for the award of an Upjohn Travelling Fellowship, and to express my gratitude to all whom I visited in the course of my investigation, for the cordiality with which they received me, the frankness with which they described their training methods, and the suggestions and advice which they offered, and to the many others who wrote, often in considerable detail, replying to my enquiries.

I should like to thank particularly Dr Robert Blair and my colleagues of the Plymouth Group, without whose training and support this investigation would not have been carried out at all, and, finally, my wife for her unfailing assistance throughout.

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Behaviour Reaction of Normal Children to Common Illnesses Treated at Home. F. E. JAMES, M.B., B.S. *The Practitioner* (May 1962), **188**, 670.

Dr James discusses the behaviour reactions precipitated in children when they have illnesses at home, and finds that though serious reactions are unusual there are, commonly, trivial or transistory abnormalities. " Whooping-cough always needs observation for psychic sequelae ". The mother may need guidance in how to manage her child.

External Cardiac Massage for Cardiac Arrest. G. A. BINNIE, L.R.C.P., L.R.C.S., D.R.C.O.G. *The Practitioner* (June 1962) **188**, 786.

Dr Binnie describes how he was with his patient at the time o- cardiac arrest due to myocardial infarction, as proved later by electrof cardiography, and how the pulse returned after the application of external cardiac massage.

Rubber Ball Pessary for Procidentia. R. BOWESMAN, M.D. *The Practitioner* (June 1962) **188**, 790.

The use of a rubber ball for supporting severe procidentia is recommended. Advice is given on the size of ball required and how it may be obtained. Management includes removing the ball for cleaning at suitable intervals, an operation which can be carried out in a variety of ways, including the use of a soup spoon or of midwifery forceps. The method is quite successful in suitable cases.