HOSPITAL TOPICS

Attitudes to Psychiatry in the General Hospital

JOHN M. KELLETT,* M.B., M.R.C.P., D.P.M. ; ALEX G. MEZEY,† M.D., F.R.C.P.ED., D.P.M.

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Summary: A survey of consultant attitudes to psychiatry in six general hospitals is presented and compared with reported findings in general practitioners and medical students.

Psychological factors were accepted as important in a variety of medical conditions. Different specialties differed little in their attitudes to neurotic patients and to psychiatrists, younger consultants tending to be more critical. Consultants had a lower level of neuroticism than the general population and medical students, and physicians were less extraverted than surgeons; these personality factors were not related to expressed attitudes.

The results suggest that other specialties accept the role of psychiatry, and its integration into the general hospital is not likely to meet with antagonism.

Introduction

The policy of integrating all medical services in district general hospitals increases the need for close co-operation between psychiatry and other specialties. Numerous surveys have been made of the attitudes towards psychiatry of medical students (Walton *et al.*, 1963), newly qualified doctors (Tucker and Reinhardt, 1968), and general practitioners (Shepherd *et al.*, 1966), but the attitudes of consultants in other specialties have not been documented, except by anecdotal accounts.

Davies (1964) found that 38% of medical and 5% of surgical outpatients were suffering from a psychiatric illness without organic disease. Munro (1969), studying new gynaecological outpatients, found 10% with a psychological abnormality. It would appear from these figures that much of the work facing hospital specialists is concerned with psychiatric conditions presenting with a somatic complaint. The present investigation was an attempt to study the attitudes of hospital consultants to psychiatric illness and to psychiatrists.

Methods

Six general hospitals in the North-east Metropolitan Region were selected on the basis of their greater size, the comprehensive service they were offering, and the varied nature—urban and rural—of the population served by them. All non-psychiatric clinical consultants on the staff of these hospitals were asked to complete a questionary. Of the 106 consultants approached 88 (83%) agreed to co-operate. The characteristics of this group are shown in Table I and compared with a representative sample of consultants in England and Wales supplied by the Department of Health and Social Security (1967). The group investigated differed from the representative sample in that it contained an excess of London-trained, younger, and whole-time consultants; there were also proportionately more physicians than surgeons.

The part of the survey reported here was concerned with the following questions:

(1) What are the attitudes of the consultants to psychological factors in physical illness? For 14 medical conditions—cancer, tuberculosis, cerebral arteriosclerosis, epilepsy, trigeminal neuralgia, coronary thrombosis, rheumatoid arthritis, essential hypertension, liability to accidents, dysmenorrhoea, vomiting of pregnancy, eczema, peptic ulcer, asthma—the consultants were asked whether, in their view, these factors were "very important," "important,"

TABLE I.—*Some Characteristics of the Consultants in the Survey Compared with a Representative Sample for England and Wales. (The Age of the Consultants in the Actual Sample is Estimated from the Date of Qualification)*

	Sample	
	Actual (n = 88)	Representative (n = 88)
All consultants in:		
Medicine	39	33
Surgery	24	34
Neurology	3	1
Dermatology	4	3
E.N.T.	8	5
Obstetrics and gynaecology	8	9
Radiotherapy	2	3
Medical specialties	46	37
Surgical specialties	42	51
Part-time	57	68
Whole-time N.H.S.	31	20
Age groups:		
Over 50	40	48
40–49	31	31
Under 40	17	9
Undergraduate clinical training:		
London	65	
Elsewhere in the British Isles	19	
Overseas	4	
Postgraduate psychiatric experience	16	

"slightly important," or "unimportant" in their aetiology and whether they considered these diseases to fall within their own specialty. Their responses were scored 3 for very important to 0 for unimportant.

(2) What are the attitudes of the consultants to psychiatry and psychiatrists? For each of 14 statements (see Questionary) the consultants were asked whether they "strongly agree," "agree," are "uncertain," "disagree," or "strongly disagree." The responses were scored 0 for strong agreement to 4 for strong disagreement. Some, though not all, statements were identical to those used by Shepherd *et al.* (1966).

(3) What is the relation between the personality of the consultants and their attitudes? It would not have been appropriate to attempt a detailed personality assessment, but every consultant was asked to complete the shortened form of the Maudsley personality inventory (Eysenck, 1958) so that two personality factors—neuroticism and extraversion—could be measured.

Results

Psychological Factors in Illness

There was little difference between those who regarded the disease as within their specialty and those who did not, the scores obtained from questionary responses averaging 1·10

* Registrar, Department of Psychological Medicine, North Middlesex Hospital, London N.18. Present address: the Maudsley Hospital, London, S.E.5.
† Consultant, Department of Psychological Medicine, North Middlesex Hospital, London N.18.

and 1·13 respectively—that is, psychological factors were considered slightly important. Obstetricians, however, believed psychological factors to be more important in dysmenorrhoea and vomiting of pregnancy than did their colleagues (2·25 : 1·40; t = 2·50, P<0·02). Younger consultants—namely, those qualifying after 1940—were less inclined to rate psychological factors as important than older doctors were (1·07 : 1·19). This was especially so for vomiting of pregnancy, where those qualifying before 1940 rated psychological factors as more than important (2·11), whereas those qualifying between 1940 and 1950 felt they were only slightly important (1·05; t = 4·02. P<0·001). Those qualifying after 1950 were intermediate. Older consultants considered psychological factors less important in rheumatoid arthritis than did those qualifying later (1·48 : 2·04; t = 2·24, P<0·05).

Psychiatric Patients and Psychiatrists

The first seven statements (see Questionnaire) were concerned with patients, and by combining statements *(a)*, *(b)*, and *(c)* we obtain an index of attitude to neurotic patients. On this basis physicians, surgeons, and obstetricians differed little (medicine 2·17, surgery 2·06, and obstetrics 1·91—the score of 4 indicating a maximally favourable attitude to neurotic patients). Similarly there were no significant differences related to date of qualification (pre-1940 2·03, 1940-50 2·20, and post-1950 2·00). When the specialties were combined into medical and surgical (including obstetrics), those in surgical specialties found neurotic patients a greater strain (0·92 : 1·37; t = 2·88, P<0·01) and believed that these patients made less attempt to get better when labelled neurotic (2·42 : 2·80; t = 2·22. P<0·05).

Questionnaire on Psychiatric Patients and Psychiatrists

Patients

(a) Neurotic patients impose a greater strain on the specialist than do other types of patients.
(b) Neurotic patients are generally ungrateful for the trouble taken with their treatment.
(c) Once the diagnosis of neurosis is attributed to a patient he makes no attempt to get better.
(d) An increasing number of my patients have psychiatric symptoms.
(e) The training of all doctors (general practitioners) to be able to deal with neurotic illness is one of the most urgent needs in medicine.
(f) Suicide is essentially a social (moral) rather than a medical problem.
(g) The treatment of associated emotional problems is an integral part of the consultant's work.

Psychiatrists

(a) Psychiatrists too often discharge patients who are not fit to be outside mental hospitals.
(b) Psychiatry has established itself as an important medical specialty.
(c) Whatever their therapeutic claims psychiatrists have little more to offer than the average general practitioner can provide.
(d) Psychiatrists should confine themselves to the psychoses.
(e) Psychiatry has made great advances in the past decade.
(f) All too often a psychiatrist will state that a patient has improved, but when I see him I can find no change.
(g) No psychiatric referral should be made until all possible physical illnesses have been excluded.

Consultants did not feel that the number of patients with psychiatric symptoms had increased. The need for better undergraduate psychiatric training was generally accepted, though younger consultants were less convinced of it (1·82 : 1·59; t = 1·06, P not significant). Suicide was regarded as a social rather than a medical problem, though physicians were more ready to see it as a medical problem than were surgeons.

The last seven statements are concerned with psychiatry and psychiatrists. Questions *(b)*, *(c)*, and *(e)* provide an index of attitude to psychiatry in general (with the scores of question *(c)* inverted), the maximum score of 4 indicating a strongly critical attitude. Again there was no significant difference between the specialties (medicine 1·30, surgery 1·43, obstetrics 1·29). Young doctors and those trained in London tended to be more critical. Consultants were equally divided on the question of early discharge of patients with mental illness. The sample were similarly divided over finding no change in patients reported by the psychiatrist to be improved. This question showed pronounced differences between hospitals, one hospital in particular expressed marked agreement with this suggestion (1·71 : 2·25; t = 2·73, P<0·01).

Consultants believed that psychiatrists have more to offer neurotic patients than the average general practitioner has. They also thought that psychiatrists should not limit themselves to psychotic illness, medical specialists being more definite than surgical specialists (3·09 : 2·61; t = 2·58, P<0·01). Consultants generally believed it important to exclude physical illness before psychiatric referral, though those in medical specialties were equally divided (medical 2·11 : surgical 1·82; t = 2·51, P<0·02). This difference may reflect the relative ease of surgical disease exclusion. Thus two out of three neurologists disagreed with the suggestion. Those with psychiatric experience and younger consultants had more confidence in psychiatrists' medical skills.

Hospitals differed in their attitudes, reflecting possibly local relationships with psychiatry. The hospital from which the survey originated had a significantly more favourable attitude to neurotic patients (2·53 : 1·97; t = 3·31, P<0·002), which might have been influenced by a wish to be tactful to psychiatric colleagues. This hospital's attitude to psychiatry, however, showed much less deviation, though still in a positive direction (1·14 : 1·38; t = 1·79, P<0·1). Another hospital, where psychiatric arrangements were unsatisfactory when the inquiry took place, showed no difference in attitude to neurotic patients but a slight and statistically not significant difference in attitude to psychiatry (1·52 : 1·36; t = 1·01).

Personality of Consultants

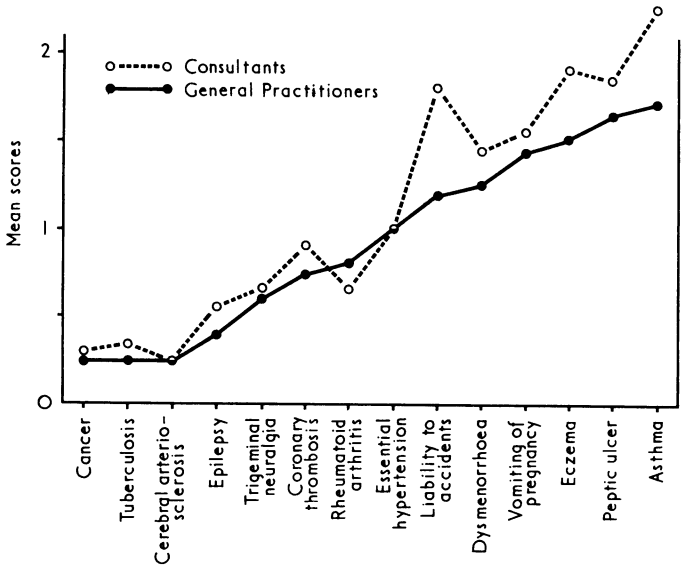
Fifteen consultants declined to complete this part of the study, reducing the effective sample to 73; four of the eight obstetricians fell into this category, rendering their sample size too small to be of value (Table II). Consultants fell close to the norm on extraversion, but much lower on neuroticism. Physicians were significantly less extraverted than surgeons (6·4 : 8·1; t = 2·54, P<0·01), but there was no significant difference between neuroticism scores. Splitting the sample on their degree of extraversion revealed no significant difference between the high and low extraversion groups as regards attitude to neurotic patients (2·10 : 2·06) or to psychiatrists (1·36 : 1·28).

TABLE II.—*Neuroticism and Extraversion Scores of Consultants on the Shortened Form of the Maudsley Personality Inventory*

	Neuroticism		Extraversion	
	Mean	S.D.	Mean	S.D.
Surgeons	3·03	3·45	8·07	2·46
Physicians	4·00	4·08	6·41	3·18
Total	3·67	3·10	7·10	2·95
Normal population	6·15	3·43	7·96	2·97

Discussion

One of the surprising findings of this survey was the similarity in attitudes of all categories of consultant staff. Though the importance attached to psychological factors in somatic disease is expressed as a mean, the detailed results show no evidence of a bimodal distribution and support the rejection by consultants of a physical-psychiatric dichotomy. Though



Consultants' estimate of importance of psychogenic factors compared with that of general practitioners (Shepherd *et al.*, 1966).

general practitioners were more impressed by advances in psychiatry (Shepherd *et al.*, 1966), they appeared to consider psychological factors in somatic disease of less importance than the consultants did (see Chart). The latter finding might be explained by a slight difference in wording, but it was found only in certain diseases. Thus general practitioners, like consultants, placed asthma first when the diseases were ranked in order of importance of psychological factors, but thought them less important than did consultants (2·25 : 1·68). A similar difference was found with "liability to accidents" (1·81 : 1·17) and eczema (1·90 : 1·49). Another possible explanation is the greater isolation of general practitioners who, unlike their consultant colleagues, cannot so readily delegate responsibility for treatment of psychological factors; they would therefore tend to lay less stress on these factors.

Despite the greater emphasis being placed on psychological factors, and their presentation in general outpatient clinics, it is interesting to note that consultants did not feel there had been an increase of these symptoms among their patients. Like the general practitioners, consultants felt that psychiatry could help neurotic as well as psychotic patients. Though all groups felt that psychiatric training in medical schools was still inadequate, there was no evidence that the greater emphasis placed on psychiatry in recent years had altered attitudes. Thus younger consultants showed a less favourable attitude to psychiatry than those qualifying before 1950 did, though the difference was slight. This would fit in with the finding of Walton (1969) that different teaching methods did not affect attitudes to psychiatry among Edinburgh medical students.

Tucker and Reinhardt (1968), on the other hand, studying newly qualified doctors selected by their choice of aerospace medicine during military service in the U.S.A., found that favourable attitudes to psychiatry correlated with a longer psychiatric education. Caplovitz (1957) found that physicians and paediatricians in the U.S.A. placed greater emphasis on psychiatric aspects of disease than surgeons and obstetricians did, but that the latter groups became more psychiatrically orientated as they gained seniority and were more so than their students. It is possible, therefore, that by the time consultant status has been reached the major differences of attitude between specialties will have been lost, either by a selective process or by experience—hence the findings of this survey. Though American experience may differ from our own, Martin (1966) found that the attitude of British medical students was similar to that of Kansas students (Becker *et al.*, 1961) in that formal teaching induced an attitude of cynicism and a loss of empathy to patients which might take several years to erase.

Thirty per cent. of the consultants approached did not complete the shortened form of the Maudsley personality inventory, and we cannot be certain what influence this had on the mean scores obtained from the two personality traits measured. The low level of neuroticism found for consultants completing the inventory may relate to the ease with which intelligent people can manipulate this type of test to give the desired impression. Nevertheless, the difference is a large one, especially when comparison is made with medical students, whose neuroticism is close to the mean for the normal population and only slightly lower than that of other students (Walton, 1969). It is possible, therefore, that a low level of neuroticism is associated with the ability to reach consultant grade. Consultants were like the medical students in being near to the norm for extraversion, but the difference between medical and surgical specialties confirms the stereotype. The absence of correlation between attitudes to psychiatry and extraversion is in agreement with Walton's (1969) findings.

Before final conclusions are drawn from this study one should remember that the attitudes are those expressed publicly to a psychiatrist and may not necessarily represent privately held beliefs. There is thus a likelihood that positive attitudes to psychiatry may be exaggerated. Another caveat is the limitation of the sample, which may only reflect the views of the consultants in a particular area of the country.

The results of this survey are encouraging for the integration of psychiatric services into the general hospital and suggest that consultants are well aware of psychological factors in illness. All consultants accepted their role in treating associated emotional problems of physical illness but, as was found in the survey of general practitioners, it is likely that this was their aspiration but not necessarily their practice. While finding the neurotic patient difficult, they could accept their own role in treatment and appreciate the help that psychiatry could give. The doubts expressed over the psychiatrists' judgement of recovery may in part derive from the recurrent nature of psychiatric illness, and this emphasizes the need for caution in patient assessment and a frank acknowledgement of the therapeutic limitations of psychiatry. In the opinion of those in other specialties, however, psychiatry need no longer consider itself outside the main stream of clinical medicine.

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