# EDITORIAL

# Psychiatry in General Practice

OVER the past two decades, data derived from outpatient and day-patient statistics, general practice samples, random surveys of the general population and psychiatric case registers have clearly demonstrated that psychiatric ill-health poses an immense challenge to the non-specialist general health and social services (Williams and Clare, 1979; Shepherd *et al.*, 1982). At the same time, the development of appropriate screening measures, such as the General Health Questionnaire (Goldberg, 1972), the semi-structured Clinical Interview Schedule (Goldberg *et al.*, 1970) and the Social Maladjustment Schedule (Clare and Cairns, 1978), by research workers at the General Practice Research Unit and their deployment in a variety of research initiatives have revealed that such morbidity is largely made up of an inextricable mix of psychological symptoms, social need and difficulty, and physical disturbance (Cooper, 1972; Eastwood and Trevelyan, 1972). In the light of these findings, a major question facing health service planners and clinicians alike is how best to respond to such a substantial pool of morbidity. Much recent research has been directed towards clarifying this particular issue.

Three distinct, though not necessarily incompatible, approaches can be identified. The first approach argues that psychiatrists in specialist settings, on a regional basis, or perhaps located in community mental health centres, should be involved more directly with the detection and management of a greater proportion of the total morbidity (Royal College of Psychiatrists, 1975; Jones, 1979). However, a number of observers on both sides of the Atlantic have pointed to deficiencies in the US Community Mental Health Center programme which make it unlikely that such a strategy would be fruitful in the British setting (Clare, 1980; Sharfstein, 1980). It is also becoming clear that the expansion of psychiatric manpower which has occurred over the past decade, while doubtless of immense significance to the psychiatric specialty, has had relatively little impact on the size or nature of the psychiatric burden shouldered by the general practitioner (Williams and Clare, 1979). In addition, there is powerful international support for strengthening the primary care physician as the cornerstone of community psychiatry (WHO, 1973; Klerman, 1979).



The second approach aims to strengthen the general practitioner's own personal diagnostic and treatment skills. Implementation of formal methods of psychotherapy within primary care settings has proven difficult and while there has been much interest in and enthusiasm for modifications, such as those advocated by Balint and his colleagues, these have not appealed to more than a relatively small number of practitioners. More recent research has focussed on identifying those medical behaviours, including interviewing skills, which appear to be related to the accuracy of psychosocial assessment and which might be significantly improved by training. Goldberg and his colleagues in Manchester and South Carolina have identified a number of such behaviours including the maintenance of appropriate eye contact, clarification of the presenting complaint at the outset of the consultation, the form of the 'problem solving' questions adopted by the general practitioner and his or her sensitivity to verbal and non-verbal cues relating to psychological distress on the part of the patient (Goldberg and Huxley, 1980). However, there is still a large gap in our knowledge between such findings and those of studies of the actual consultation process which demonstrate the extent to which treatment is symptomatically rather than diagnostically based and the remarkable variation between doctors in their prescribing patterns and habits (Raynes, 1980; Raynes and Cairns, 1980).

Given that the major form of treatment adopted by the general practitioner in the management of mental illness in primary care is the prescription of psychotropic medication, much research has been directed at clarifying the factors which generate such prescribing and which encourage long-term use. The importance of studying the 'why' of psychotropic drug prescription has become even more important as the wider associations of drug-taking are explored. In addition to the studies on the consultation process already mentioned, research has focussed on recent trends in prescribing (Williams, 1981), and the relationship of such prescribing to physical disease (Williams and Courtenay, 1979), seasonal variation, alcohol consumption and national prescribing trends (Williams and Dunn, 1981). In addition, the initial use of psychotropic drugs does appear to be linked with acute life crises, the effects of which seem to be prolonged by the absence of appropriate social support (Murray *et al.*, 1982). This same study con-

firmed that long-term psychotropic users are often characterized by loneliness, unsatisfying marriages, lack of engagement in social activities and a feeling of 'not belonging' (Balint *et al.*, 1970). A longitudinal study of psychotropic drug consumers suggested that those factors which increase the risk of becoming a chronic user include age, a history of previous psychotropic drug use, higher levels of psychological symptomatology at the inception of treatment and, for women only, social problems as perceived by the general practitioners (Williams *et al.*, 1982).

The third approach is related to the fact that so much of the psychiatric morbidity detected in primary care has to be conceived in medicosocial rather than purely medical terms. Research has focussed on the contributions of other primary care personnel, most notably the social worker and, to a lesser extent, the health visitor, psychologist and the community psychiatric nurse, to the task of detection and treatment of psychosocial morbidity. At the General Practice Research Unit, research funded by the DHSS and carried out over the past 10 years has established the feasibility, practicality and, most important, the efficacy of deploying social workers alongside general practitioners in the primary care centre (Cooper *et al.*, 1975; Corney and Bowen, 1980; Corney, 1982). The advantages and disadvantages of such a strategy, which encompass professional, ideological, training and administrative differences and issues, are described and assessed in a recent book which collates the fruits of this and allied research ventures (Clare and Corney, 1982). A similar strategy is currently being employed with regard to the actual and potential role of the health visitor (Briscoe and Lindley, 1982) while other initiatives have involved the use of counsellors (Ashurst, 1982), nurse practitioners (Waters, 1981; Paykel *et al.*, 1982) and psychologists (Eastman and McPherson, 1982; France and Robson, 1982).

The role of the psychiatrist as a consultant to and even member of the primary care team has more recently come under research scrutiny (Cooper, 1982; Regier, 1982). At the present time, evidence is being accumulated concerning the nature and extent of the involvement of psychiatrists (Williams, P. and Clare, A., unpublished results) and a project is under way on the evaluation of different methods of liaison and consultation between psychiatrists and general practitioners in primary care.

There is a pressing need for further clarification of the natural history of psychosocial morbidity. A unique 20-year follow-up of patients in John Fry's Beckenham practice affords a remarkable over-view of such morbidity. This study has already demonstrated the high incidence of disorders diagnosed by general practitioners as wholly or partly psychiatric in nature. The figures for those attending their doctor with anxiety or a phobic state are about even for the sexes, but more than two times more women than men attend with a depressive episode. It is also becoming apparent that these disorders are handled almost entirely by the general practitioner—only 84 of 1,530 patients were referred to a psychiatric outpatient department and only 47 were admitted (Shepherd and Clare, 1982).

Such research ventures as have been described, while innovative and encouraging, are handicapped by the relatively crude classification of disorders currently used within primary care, the remarkable variation in detection and management between general practitioners, and the relatively fragmented nature of the medical and social services. In this context Howie's five categories of research are highly applicable, including as they do the therapeutic assessment of drugs and other treatments, natural history studies of illnesses, preventive, educational and screening activities, diagnostic and management decisions, and practice organization (Howie, 1979). Michael Shepherd summarized the 1981 Oxford Conference on Psychiatry and Primary Care (Shepherd, 1982) as follows:

> 'The case for intensive investigation along a broad front has now been established, but so far the surface has barely been scratched.'

The time is certainly ripe for more vigorous excavation.

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# Career preferences of doctors qualifying in the United Kingdom in 1980

General practice (36.8 per cent of all first choices corrected for ties) was the most popular first choice of career, followed by medicine (18.2 per cent) and surgery (15.9 per cent). Medicine (17.1 per cent) was the most popular second choice and general practice (9.6 per cent) and most popular third choice. Among first choices, dermatology (0.9 per cent) was the most popular medical subspecialty, while ophthalmology and orthopaedics (both 2.0 per cent) were by far the most popular surgical subspecialties.

Paediatrics and community medicine were relatively popular first choices among women, surgery being by far the least popular major specialty. Dermatology, accident and emergency, and ophthalmology were relatively popular subspecialties among women.

As in previous years, there was a considerable variation between medical schools, but it should be noted that small percentages in the table usually corresponded to very small numbers of choices.

Among 1980 qualifiers, general practice was the most popular first choice of career at all medical schools except Cambridge, where surgery was chosen most often, and the Westminster, where both medicine and surgery were more popular. The percentage of first choices for general practice was highest at the Royal Free (48.9 per cent) and lowest at the Westminster (21.7 per cent); on the other hand, the percentage of first choices for medicine was lowest at the Royal Free (6.9 per cent) and highest at the Westminster (28.0 per cent). Choices for surgery ranged from 8.2 per cent at Aberdeen to 29.0 per cent at Cambridge.

For the other specialties, a number of medical schools showed percentages of first choices which differed appreciably from the norm. Psychiatry was relatively popular at Leicester, a medical school appearing in the surveys for the first time: 10.9 per cent of the 32 Leicester respondents gave this specialty as a first choice. Psychiatry at St George's (8.3 per cent) and anaesthetics at St Thomas's (12.5 per cent) were relatively popular among 1980 qualifiers in 1981, as they had been among 1979 qualifiers surveyed in 1980. Paediatrics at both Sheffield (6.9 per cent) and University College (10.1 per cent), and radiotherapy and oncology at the Westminster (5.7 per cent) were also popular first choices among 1980 qualifiers, but not among 1979 qualifiers. The relatively high percentages of first choices for community medicine at Charing Cross and pathology at Oxford noted among 1979 qualifiers had faded somewhat.

Source: Parkhouse, J., Campbell, M.G., Hambleton, B.A. *et al.* (1983). *Health Trends,* **15**, 12-14.