# Middle Articles

## GENERAL PRACTICE OBSERVED

# Participation of General Practitioners in Community Psychiatry*

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Most patients referred to specialist psychiatric services in Britain are from general practitioners (G.P.s). With the increasing trend towards treating mentally ill patients in the community, G.P. participation in the mental health services has become even more important. The G.P. is usually best placed to evaluate family and social stresses and provide for long-term continuity of care. But, because the G.P.'s precise role in the local mental health services has remained ill-defined and diffuse, the degree of participation one might expect from him is uncertain.

Most studies of psychiatric illness in general practice have been concerned with the prevalence of mental disorder. The size of a G.P.'s practice, the time-consuming nature of the cases, and his attitude to and training in psychiatry have all been thought to influence his approach to such patients (Mowbray *et al.*, 1961 ; Rawnsley and Loudon, 1962). In a more recent study Cooper (1964) found that, though in general most G.P.s were well aware of the social and psychological stresses undergone by their patients, they were preoccupied with a shortage of available time. Though many were willing to take on more psychiatric patients, a number expressed their misgivings about their role when it came to treating the more disturbed patient. Cooper's study was based on a postal questionary submitted to a selected group of 167 G.P.s who were all members of the College of General Practitioners. A recent investigation by Cartwright (1967) suggests that G.P.s belonging to the College are more interested in psychiatry than non-members ; this finding may account for the overall positive attitude towards psychiatry found in Cooper's study.

Shepherd *et al.* (1966), in a comprehensive survey, were critical of the family doctor's role in the mental health services. The G.P.s in their study were not a random sample, but were thought to be a representative cross-section of the profession. Most of these G.P.s regarded treatment of neurotic illness as part of their job ; yet they were often found to be ill equipped for this. Treatment was mainly confined to drug therapy, satisfying a need for active clinical intervention, but patients received very little counselling or reassurance and scant attention was paid to social factors.

As future developments in the psychiatric services will depend on the G.P.'s collaboration, it is important to have some idea of his contribution at the present time, and what factors, if any, influence him. The investigation reported here is a further attempt at clarification.

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### Survey of General Practitioners

The survey was conducted in 1963–4 in an urban area, now part of a Greater London borough. Its main aim was to find out the extent to which G.P.s of a locality participated in the local mental health service, and how much can be expected of them in contributing to the care of psychiatric patients in the future. As this contribution depends on several factors, some attempt was made to isolate these. Foremost may be a G.P.'s interest in psychiatry and the nature of his psychiatric undergraduate and postgraduate training. Also important is the available time he has for his patients, though to some extent this may be a function of the size of his practice and the volume of his other commitments. Although this survey was concerned with G.P.s in a single urban area, and may not necessarily be representative of the country as a whole, it would seem that information of this kind is useful for both the future planning of community psychiatric services and for the content of a G.P.'s training programme.

### Method

A sample of 75 G.P.s was constructed by random sampling numbers from the list of 127 G.P.s on the local executive council who had their surgeries in the county borough surveyed. Four G.P.s were either too ill to be interviewed or had retired, and two refused co-operation, so that the study is based on results obtained from interviews with 69 G.P.s. The procedure was based on a pilot study with 10 G.P.s.

Each G.P., after an approach by letter, was interviewed first by the psychiatric social worker and then, approximately one week later, by the psychiatrist. The G.P. was asked for certain factual information about himself and his practice in a structured interview designed to clarify his willingness to participate in the treatment of psychiatric patients and to disclose his orientation towards psychiatry. There was some difference in emphasis between the two interviews, the first concentrating on the local situation and the second on general interest and training. The interviewers completed a questionary for each G.P. immediately after each interview and without reference to each other. Duplication of certain questions in both interviews and the inclusion of some questions of fact which could be verified objectively gave some indication of the reliability of the information obtained. The information was then grouped into three main categories in respect of the G.P.'s apparent interest in psychiatry, his use of the local psychiatric service, and his view of the part he should play in this. In addition, all adult referrals made by G.P.s during one year (1962) were recorded and analysed. A referral rate per thousand patients on his list was calculated for each G.P.

## Results

Some details of G.P.s in the sample are given in the Table. All data were obtained from the G.P.s themselves.

*Profile of 69 General Practitioners*

| G.P.s' Estimate of Size of Practice | | Year of Qualification | |
|---|---|---|---|
| 1,000 | 1 | Before 1941 | 34 |
| 1,000–1,499 | 2 | 1941–6 | 8 |
| 1,500–1,999 | 5 | 1947–52 | 21 |
| 2,000–2,499 | 10 | 1953–7 | 6 |
| 2,500–2,999 | 13 | 1958–63 | 0 |
| 3,000+ | 38 | | |

| | | |
|---|---|---|
| Partnership | | 54 |
| Single-handed | | 15 |
| Ancillary help | Yes | 47 |
| | No | 22 |
| Postgraduate psychiatric experience | Yes | 22 |
| | No | 47 |
| Undergraduate psychiatric experience | Yes | 49 |
| | No | 20 |
| Other clinical commitments outside practice | Yes | 30 |
| | No | 39 |

There were nine women in the sample. The proportion of single-handed to group practices was less than the national average at the time of the survey, but the average size of practice was similar to that of the country as a whole. None qualified after 1957, and there was a preponderance of older G.P.s in the sample.

"Ancillary help" in the Table covered the regular employment of a nurse or receptionist. Undergraduate experience in psychiatry was defined as systematic training in psychiatry consisting of a minimum of 12 lectures or demonstrations undertaken by the staff of a medical school, and excluding isolated visits to mental hospitals. Postgraduate experience in psychiatry was defined as a course in psychiatry at a postgraduate institute, regular attendance at a series of seminars, or appointment in a psychiatric clinic or hospital, in each case covering a period of six months or longer. Clinical commitments outside general practice included work such as part-time appointments with the local health authority, medical consultant to a voluntary organization, or medical officer to local industrial organizations. None of the G.P.s had an appointment with the local psychiatric services.

## G.P.'s Attitude to Psychiatry

Certain items in the questionary were designed to identify the attitude of the G.P. towards psychiatric problems in his practice.

Each G.P. was questioned in some detail on his use of psychopharmacological preparations (tranquillizers, antidepressants, sedatives) in respect of hypothetical case examples, and replies were then analysed according to knowledge of potential action of side-effects, and of indication for prescription in appropriate cases—42 (61%) of the G.P.s had a good knowledge of the use and action of drugs in psychiatric practice and used them extensively. In addition, a further nine G.P.s had good knowledge but did not prescribe them for reasons which varied from a fear that the drugs might lead to addiction, to scepticism about their long-term efficacy. The remaining 18 were uncertain about the appropriateness of drugs in different psychiatric illnesses and on the whole did not use them. When the replies were correlated with individual details those G.P.s who had qualified since 1940, or who had some postgraduate psychiatric experience, showed a statistically significant greater knowledge of these drugs, though this did not hold good for the extent to which they were prescribed.

G.P.s were asked whether they would be willing to attend local seminars in psychiatry conducted on a regular basis at a time to suit their convenience. Twenty-six expressed a positive interest, and of these a statistically significant majority had some postgraduate experience in psychiatry. None of them considered that their undergraduate training in psychiatry had been adequate. Though 61 out of the 69 commented on the limitations of available time in respect of any "in-service" psychiatric training, those in favour felt that organization within their practice could overcome this difficulty and be to their considerable benefit.

G.P.s were invited to describe in their own terms the types of psychiatric patient whom they found most easy and those most difficult to deal with. Sixty preferred to deal with neurotic illness, which they regarded as part and parcel of general practice, rather than psychotic illness, where treatment was seen as the responsibility of the psychiatrist. On the other hand, the remaining nine preferred to deal with psychotic illness on the grounds that symptoms were more clear-cut and recognizable and easier to treat with appropriate drug therapy.

All G.P.s were asked whether they had a special interest in psychiatric problems in their practice. Fourteen expressed a strong positive interest and felt that psychiatric illness was the most challenging and rewarding part and formed the highest proportion of their case-load. This personal interest did not correlate with such objective criteria as extent of undergraduate training in psychiatry, size of practice, and year of qualification. As might be expected, there was a significant correlation with knowledge and use of drugs, willingness to accept psychiatric patients on the G.P.'s list, postgraduate training, and interest in attending local seminars on psychiatry.

## Attitude Towards Use of Local Psychiatric Services

Forty-four (64%) of the G.P.s said they were satisfied in general with the local psychiatric services. This opinion was unrelated to any of the characteristics given in the Table. To a large extent satisfaction with the services was influenced by the speed with which difficult psychiatric problems or emergencies were taken over by others. Many of the G.P.s commented on the difficulty of hospital admission and viewed unfavourably the procedure for compulsory admission arising from the Mental Health Act, 1959. Previously to this duly authorized officers of the local authority were able to admit disturbed patients for observation without seeking recommendation from the G.P.

The replies of the 25 most dissatisfied G.P.s similarly centred on the inadequacy of services for relieving the G.P. of responsibility for difficult problems of behaviour presenting as emergencies. At this time an emergency "walk-in" clinic had not been set up, so there was some real basis for complaint. They felt there was a lack of appreciation of the pressure put on them by relatives to secure immediate admission and did not think that even if more psychiatric consultant advice were available this would help very much.

All 69 G.P.s used the local psychiatric services, though to a widely varying degree. The services included outpatient clinics at the local general hospitals, domiciliary consultations, mental welfare department of the local authority, child guidance clinic, and day hospital. Preference was ranked in the order listed above, and though no G.P. made use of all the facilities available many relied heavily on one or the other. Fifty-four estimated that they referred one or more patients to three out of five facilities during the course of a year.

The extent of use of the local services was not related to the year of qualification, nor to undergraduate or postgraduate experience, but, not surprisingly, fullest use was related to the largest practices.

Estimates made by individual G.P.s about their use of local psychiatric services were checked against actual practice by examining the records of referrals to all the local facilities during 1962. The 69 G.P.s referred an average of 5.2 patients per 1,000 of their estimated practice. This is slightly higher

than the referral rate of 4.4 per 1,000 patients found by Taylor and Chave (1964) in a new town. The referral rate for this London borough might be expected to be larger in view of the more extensive psychiatric facilities available. Four G.P.s referred no patients at all, 37 referred fewer than the average, and 28 referred above the average. The highest referral rate was 13.66 per 1,000. To illustrate the complexity of factors involved in determining referral rates, this high rate came from a doctor in the younger age group, who had had six months' postgraduate training in psychiatry, was obviously able to recognize psychiatric illness, but stated that he had no interest in treating psychiatric patients himself and considered that this was the psychiatrist's task. Of two doctors who each referred one patient only during the year one had practised psychiatry before entering general practice and preferred to treat his psychiatric patients himself, and the second had had no undergraduate or postgraduate psychiatric experience and frankly admitted his hostility towards psychiatric problems.

There was no significant correlation between referral practice and any of the characteristics given in the Table. Even those who by their own estimate used the local services fully did not refer a significantly higher proportion of patients ; nor did expressed satisfaction or dissatisfaction with service affect referral rates. Each G.P. was specifically asked at interview, however, to identify in order of precedence the factors he thought to be important in influencing his decision to refer a patient to a psychiatrist. For the whole group the reasons given, in descending order of frequency, were failure of response to the G.P.'s treatment, severity of symptoms, lack of time for dealing with psychiatric problems, desire for confirmation of the G.P.'s diagnosis, and pressure from patient or relative for a second opinion.

## Role of G.P. in a Community Mental Health Service

The third group of questions concerned the G.P.'s opinion of his own role in an area mental health service. Each was asked whether he would be willing to take on his list more psychiatrically ill patients than those he had at present, given adequate consultation and advice from the psychiatric services. Of the 69 G.P.s only eight said they would be willing to do so, and of these eight six had postgraduate experience in psychiatry. The majority of G.P.s commented that time was the most important factor in deciding whether or not to take on a new patient with a history of psychiatric illness. More than half of them thought that general practice was unsuited to cope with anything but minor psychiatric illness where a reasonably quick response to palliative measures might be expected. Despite the view that they had time only for superficial investigation, 31 of the 69 G.P.s said they normally interviewed the relatives of psychiatric patients. Some made a special point of doing so.

The G.P.s were asked whether they would be prepared to have a psychiatric social worker attached to their practice. To the majority this was a novel, previously unconsidered possibility, and many questioned the function of a social worker in general practice. Three were firmly against the idea, while four welcomed it.

Questions were also asked about the type of aftercare arrangement preferred by a G.P. for patients discharged from hospital. Seven said they would prefer to resume full care of their patients immediately on discharge, but the remainder wanted to continue psychiatric supervision until the patient had fully recovered symptomatically. Where discharged patients failed to present themselves on referral back to the G.P. 11 of the G.P.s said they would make some positive effort to see the patient. The remainder thought that general practice was not geared to long-term supervision of severe psychiatric illness, though they were aware of the risk of relapse.

## Discussion

This type of inquiry must be treated cautiously when one attempts to draw conclusions from answers that have a strong subjective bias. With this proviso, however, such a study is thought to be of some value in so far as it represents the views of an unselected group of G.P.s who were interviewed independently by two observers.

In a pamphlet entitled "The Part of the Family Doctor in the Mental Health Service" the Ministry of Health (1961) emphasized the role of the family doctor in early recognition of psychiatric illness and stressed that effective management required a team effort by G.P., psychiatrist, and social worker. In a further report the Ministry of Health (1963) suggested that the G.P. might be the person to co-ordinate the supporting clinical and social services which are part of community psychiatric care. These official expectations seemed not to have taken into account the lack of homogeneity existing among G.P.s. We found that the randomly selected G.P.s of our study represented many professional interests with a wide range of opinion on the importance of psychiatry in general practice. The general picture seems to be one of indifference to psychiatry and little awareness that changes in the care of the mentally ill are likely to affect the future role of family doctors.

Reports of the prevalence of psychiatric illness in general practice suggest that the family doctor deals with a high proportion of mild cases without referral to a psychiatrist (Watts *et al.*, 1964) and accepts neurotic patients as part of the general clinical load.

How the G.P. actually handles his psychiatric patients is outside the scope of this study, but the answers to certain items of the questionary do give some indications of the G.P.'s limitations in this respect. Under two-thirds of the doctors interviewed had a sound knowledge of the use of and action of psychotropic drugs. This is consistent with the finding of Shepherd *et al.* (1966), where records suggested unsystematic prescribing and inadequate and haphazard treatment of minor psychiatric illnesses.

It is significant that those G.P.s who had undergone postgraduate training were more willing to accept responsibility for psychiatric patients. This minority were also distinguished by their better knowledge of drugs and their greater interest in attending local psychiatric seminars. This finding does suggest that a G.P.'s awareness of psychiatric problems can be stimulated by psychiatric postgraduate training, though awareness is not necessarily synonymous with interest.

G.P.s in our sample were resistant to additional patients with psychiatric, and especially psychotic, illnesses. Neither did the majority welcome the possibility of providing continuous aftercare for their chronically disabled patients, and only a small proportion were prepared to consider it. On the whole they felt chronically ill patients to be the responsibility of the local psychiatric services until such time as they had recovered and were symptom-free.

The results of this particular survey suggest that it may be overoptimistic to place the onus of responsibility for the organization of psychiatric community care on the G.P. as leader and co-ordinator of a multidisciplinary team. Not only is there an individual variation of interest in psychiatry, but the G.P.'s concept of his role is one of detachment from the organization and operation of specialist psychiatric services.

Cartwright (1967) in her study comments on the present uncertainty of G.P.s concerning their precise role within the network of health services. The change in pattern of disease, with a decline in acute illness and increasing specialization within hospitals and more emphasis on the need for long-term care and rehabilitation in the community, places different responsibilities on the G.P., needing a different approach to his work than that implied by traditional clinical training. It had

been suggested that the G.P.s need better access to ancillary services, but on present evidence it is doubtful if, even if such help was available, they would be able to make full and proper use of them. If the G.P. is to take on a key role in the community services his training will require considerable reorientation, with much more emphasis on the medical needs of society and on the behavioural sciences.

More direct consultation of G.P.s by the local health authority may make them feel more active participants rather than passive consumers of services. The trend towards group general practice should favour the introduction of local authority ancillary staff and help to improve integration with social and welfare services. Experiments on these lines are already in operation, but not so far on a scale which allows proper assessment of their value.

Until general practice undergoes a fairly drastic reorganization in its method of training, and in its relation with hospital and local authority services, it is unrealistic to expect that the G.P. can achieve his potential contribution to the management of psychiatric cases in the community.

## Summary

This article describes a survey of a randomly selected group of general practitioners in one of the Greater London boroughs. The aim of the study, undertaken in 1963–4, was to get some idea of the G.P.'s attitude towards psychiatry and his willingness to participate in a local mental health service. This has become increasingly important in view of official expectations that the G.P. can be the future leader of social service and nursing personnel working in the community.

Each of the 69 G.P.s interviewed was seen twice. The interviews were based on a structured questionary, with some difference in emphasis between them. The findings suggest that the G.P.'s ability to participate in a local psychiatric service is very limited. Those who had undergone psychiatric postgraduate training seem to be in a position to make a much more positive contribution. At present the G.P.'s concept of his role is one of detachment from the organization and operation of specialist psychiatric services, and until general practice undergoes some reorganization in its methods of training and its relation with hospital and local authority services it is unrealistic to expect any more from it.

We express our thanks to the general practitioners who collaborated in this study for their courtesy and the time they gave for frank discussion. From Miss A. Lane and Mr. G. W. Kalton we obtained valuable advice and assistance on the statistical evaluation; and without the financial support of the South-west Metropolitan Regional Hospital Board this investigation would not have been possible.

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# NEW APPLIANCES

## Improved Plastic Endotracheal Tubes

Dr. M. K. SYKES, reader in anaesthetics, Royal Postgraduate Medical School, London W.12, writes: Plastic cuffed endotracheal tubes are being used increasingly for maintenance of the airway in an attempt to avoid the hazards associated with tracheostomy. Fixation of these tubes is not easy, and there is a risk of inadvertent intubation of one bronchus if the tube is too long. The position of the tube can be checked on a radiograph. However, it is often difficult to identify the position of the tip of the tube, particularly if the patient is obese or the radiograph is incorrectly exposed. To overcome this difficulty a tube has been designed with a radio-opaque marker placed close to the tip (Fig. 1). The marker is located in the channel in the tube wall which is normally used for inflating the cuff. The lumen of this channel just below the cuff is blocked off with a plastic rod and the marker is then inserted. The marker consists of a ½-in. (1.3-cm.) length of grade 18/8 stainless steel rod. This is held in place by another length of plastic rod, which is also cemented into the tube. The marker is thus situated close to the end of the tube and is clearly visible on the chest radiograph (Fig. 2).

The tube is manufactured by Portex Ltd., Hythe, Kent.

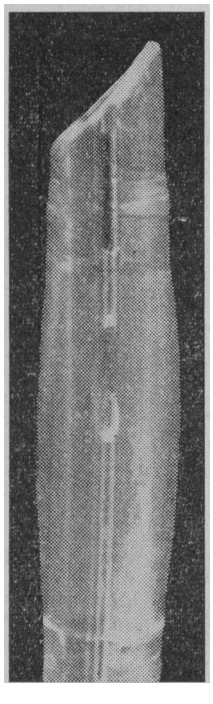

FIG. 1. — Improved plastic endotracheal tube, showing radio-opaque marker.

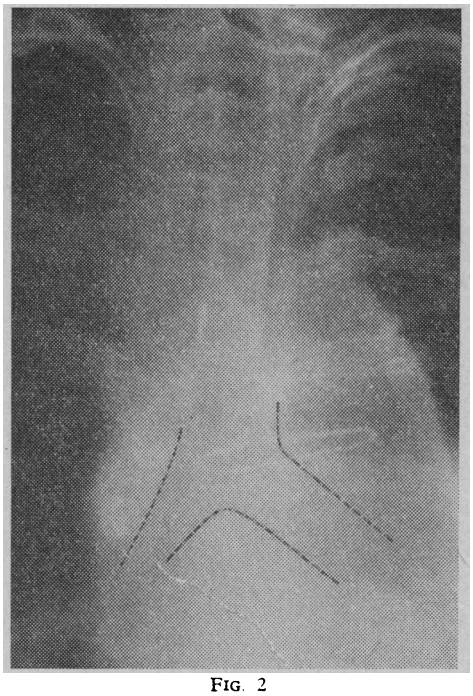

FIG. 2

FIG. 2.—Part of the postoperative chest radiograph showing the endotracheal tube, the marker being situated behind the sternoclavicular joint. The loop shown in the lower part of the radiograph is a wire suture used to unite the sternum. The broken lines indicate the carina and main bronchi.