Psychiatry and general practice: results of a survey of Avon general practitioners

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SUMMARY. A survey of general practitioners' views on psychiatry and the psychiatric services within an area has shown that considerable problems exist between general practitioners and psychiatrists over the care of patients with mental illness.

Introduction

THE two morbidity studies in general practice in England and Wales in 1955 and 1971 (General Register Office 1958-62; RCGP *et al.*, 1974) have shown that there has been a considerable increase in consultations for mental illness in general practice between the two survey years, the number of patients consulting (at least once) per 1,000 patients registered with the doctors having more than doubled. There have been two major contributions during these years to the understanding of this large part of the general practitioner's workload. One was the contribution of Shepherd and colleagues (1966) and the other, relating more to management problems, by Balint (1957).

Method

In an attempt to assess general practitioners' attitudes to psychiatry and the local psychiatric services we circulated a large questionnaire in September 1978 to all general practitioners who were in contract with Avon Family Practitioner Committee. A number of the questions were taken from the survey described by Shepherd and colleagues in 1966. Two hundred and sixty-eight (63 per cent) completed questionnaires were returned from a total of 424 general practitioners. One reminder only was sent to those who had not replied to the first posting. A few general practitioners (24) were excluded because Avon was not their 'main' family practitioner committee or because they had a limited list of patients. There were no significant differences in age, sex, group size, district and whether the doctor worked in a health centre or not, between respondents and non-respondents. Most questions were answered on a five-point scale between 'strongly agree' and 'strongly disagree', and these were contracted for analytical purposes to a three-point scale: 'agree', 'uncertain', 'disagree'.

Results

1. *General practitioners' attitudes to psychiatric illness*

The proportion of patients whose complaints were identified by the general practitioners as mainly or entirely psychogenic is shown in Table 1.

In order to help determine their opinions about the cause of most of these psychogenic symptoms additional questions were asked and the results are shown in Table 2.

We wanted to find out what the general practitioners felt about community care of mentally ill patients. Thirty-one per cent agreed that "Psychiatrists too often discharge patients who are not fit to be outside mental hospitals", whereas 20 per cent were uncertain, and 49

Table 1. Percentage of patients identified by general practitioners as having psychogenic problems.

Patients with psychogenic problems	General practitioners
0-10	*11.0*
10-20	*35.3*
20-30	*33.3*
30-40	*12.2*
40-50	*5.1*
50+	*3.1*

Table 2. Extent of agreement about the causes of the psychogenic symptoms identified (given in percentages).

	Agree	Uncertain	Disagree
1. Most mental disturbances in adult life can be attributed to emotional experiences in childhood	33	26	41
2. Some people have basically inadequate personalities and medical treatment can never help them	90	5	5
3. The distress shown by many neurotic patients is due to lack of control rather than to real suffering	40	17	43
4. The most common single cause of mental illness is inherited constitution	22	30	48
5. Today we are seeing an increase in neurotic illness due to a lack of purpose in life	75	13	12

per cent disagreed. Twenty-seven per cent agreed with the statement: "The present trend towards treating mental patients in the community has gone too far" while 17 per cent were uncertain, and 56 per cent disagreed. There is thus a substantial number of doctors who are unhappy about this aspect of modern psychiatric management. To emphasize this further, 30 per cent disagreed with the statement that psychiatry has made great advances in this past decade.

Forty-two per cent agreed that "All too often a psychiatrist will write to say a patient has improved with treatment, but when I see the patient I can find no change", 14 per cent were uncertain, and 44 per cent disagreed, underlining further the dissatisfaction of general practitioners with psychiatric treatment.

We asked the doctors whether they felt that the role of the church in helping emotionally disturbed patients was underrated: 56 per cent agreed that it was, 21 per cent that it was not. In answer to the statement: "To-day we are seeing an increase in neurotic illness due to the lowering of moral standards", 42 per cent agreed and 36 per cent disagreed. Only 19 per cent agreed that suicide is essentially a moral problem rather than a medical one; 19 per cent were uncertain and 62 per cent disagreed.

We tried to discover what general practitioners' attitudes were towards patients with psychiatric illness, and only eight per cent disagreed that the treatment of emotional problems is a major part of a general practitioners' work, 87 per cent agreeing.

In answer to the statement: "Personally I feel competent to treat most of the emotionally disturbed patients I see", 70 per cent agreed, 18 per cent were uncertain, and 12 per cent disagreed.

Sixty-one per cent agreed that they hesitated to refer because of a feeling that the treatment of neurotic patients is the job of the general practitioner (11 per cent were uncertain and 28 per cent disagreed).

Two statements helped to identify those general practitioners who might opt out of treating mentally ill patients. Twenty-three per cent agreed that "The routine care and supervision of discharged mental patients is the responsibility of the local authority social worker rather than the general practitioner"; 17 per cent were uncertain, and 60 per cent disagreed. Only 14 per cent agreed that "As a rule patients with social problems, such as housing difficulties, can be helped more effectively through a psychiatric clinic than by the efforts of a general practitioner"; 14 per cent were uncertain, and 72 per cent disagreed.

In order to see whether the general practitioners felt that they had a psychiatrically orientated doctor in the practice, we asked whether psychiatric patients tended to go to one particular partner. Twenty per cent agreed that this was so, 10 per cent were uncertain, 62 per cent disagreed and the remainder were in single-handed practices. When asked whether the respondent tended to see most of the psychiatric problems in the practice only 10 per cent agreed that this was so.

Forty-three per cent would like further training in the management of neurotic disorders, 25 per cent were uncertain, and 32 per cent would not like this. Some of the latter group are doctors nearing retirement who felt that it was inappropriate to learn new methods. Asked whether they would like to have a consultant psychiatrist visiting practices at regular intervals to discuss problem patients, only 33 per cent said they would, 23 per cent were uncertain, and 44 per cent would not.

2. *Psychiatric treatment in general practice*

The treatment of patients with psychiatric illness in general practice is complex, involving drugs, counselling, psychotherapy, and sometimes referral to specialists.

We asked the doctors to react to the provocative statement that psychotropic drugs are underprescribed in general practice. Only three per cent agreed; 87 per cent disagreed. In answer to the statement that these drugs treat only the symptoms and do not affect the cause, 66 per cent agreed and 21 per cent disagreed; 13 per cent were uncertain.

Treatment by traditional psychotherapy is difficult in general practice—finding half an hour for a patient on a regular weekly basis is considered by many practitioners to be impracticable. In answer to the statement: "Under present conditions it is not practicable for a general practitioner to engage in psychotherapy", 62 per cent agreed and 28 per cent disagreed. Those doctors who have undertaken postgraduate training in psychiatry (34) agreed that it is practicable to engage in psychotherapy ($p<0.01$). Despite this large rejection of psychotherapy, 88 per cent felt that it was important to involve

the patient's spouse in counselling and psychotherapy. Perhaps it is the term 'Psychotherapy' that the doctors are rejecting rather than the present procedure it implies?

General practitioners seem to be happy to manage their patients with psychiatric problems. In answer to the question: "If there were unlimited resources what proportion of your patients with psychogenic problems would you refer to a psychiatrist?" 70 per cent of the doctors felt they would refer less than 20 per cent of their patients. The suggestion that "Ideally the general practitioner's team should include a social worker" was greeted with acclaim by 79 per cent of the doctors, only 10 per cent disagreeing. There was less certainty about the statement that psychiatric community nurses should be based on general practice—only 42 per cent agreed and 26 per cent were uncertain.

If a doctor is not able to find time for psychotherapy patients can be referred, or go voluntarily, to non-medical counselling facilities. Fifty-eight per cent of general practitioners felt there should be more of these services, 20 per cent disagreed. However, when asked how many patients they had referred over the past year to a marriage guidance council and/or voluntary counselling service, 47 per cent said they had referred one to three patients and 32 per cent had referred no patients to marriage guidance councils; 29 per cent referred one to three patients and 58 per cent referred no patients to voluntary counselling services.

It seems that the general practitioner is not actively referring his patients in large numbers to these agencies; perhaps not surprisingly when 70 per cent say that they are competent to treat most of the emotionally disturbed patients they see, and 61 per cent hesitate to refer patients for psychiatric advice because of a feeling that the treatment of a neurotic patient is the job of the general practitioner.

3. *Referral to psychiatrists*

Seventy-seven per cent of doctors claim that they refer less than 10 per cent of their patients with psychogenic problems to a psychiatrist. When asked how many patients they had referred to a National Health Service psychiatrist for non-specific psychiatric assessment in the previous year, most claimed that they had referred more than four patients (Table 3).

Table 3. Referrals to psychiatrists.

Percentage of doctors referring	Number of patients referred
6	0
22	1-3
31	4-6
41	6+

The suggestion of seeing the psychiatrist usually comes from the doctor (71 per cent), but younger doctors (less than 40 years) are more likely to disagree with this statement than older doctors ($p<0.05$).

A large proportion of the doctors (41 per cent) claimed that it was difficult to get a satisfactory outpatient appointment. It is difficult to be certain what they meant by this. One possibility is that they are doctors who are generally unhappy with the psychiatric services and, in fact, those doctors who think that "Too often a psychiatrist writes that the patient has improved but when I see that patient I can find no change" more often found difficulty in getting an outpatient appointment ($p<0.0001$).

In order to determine why this difficulty exists and why only less than 10 per cent of patients are referred, we asked a series of questions headed "I hesitate to refer patients for psychiatric advice because of . . . ." (Table 4).

It seems that the main reasons are the general practitioners' feelings that patients do not like referral to psychiatrists and their frustration at the delay in getting the patients seen, against a background of strong feeling that treatment of neurotic patients is the job of the general practitioner.

Of those 41 per cent of doctors who state that they have difficulty in getting satisfactory outpatient psychiatric appointments, significantly more of them hesitate to refer because of problems with psychiatry in general (Table 5).

The differences between doctors having difficulty and those with no difficulty are not significant in relationship to the following questions.

I hesitate to refer because of:

1. The disadvantage to patients of being labelled as mental cases;
2. My belief that little help can be given;
3. A feeling that the treatment of neurotic patients is the job of the general practitioner;
4. The psychiatrist's delay in sending reports on patients referred to him.

These tend to emphasize the unhappiness a number of general practitioners experience with psychiatric services and their possible failure to use them to their full potential.

General practitioners' difficulties increase when the referral is urgent (opinion needed within 24 hours). Fifty-six per cent agreed that it was difficult, six per cent were uncertain, and 38 per cent disagreed. Unlike the difficulties in getting an 'ordinary' appointment, doctors wanting an urgent appointment had greater difficulty in some districts than in others ($p<0.01$).

Nineteen per cent had difficulty persuading a consultant psychiatrist to make a domiciliary visit and again there was considerable inter-district variation. Younger doctors express greater difficulty than those over 40, perhaps owing to lack of experience or simply because they have had less time in which to build up a good working relationship with the consultants ($p<0.05$).

Table 4. Problems about referral.

	Percentage agreeing			
	Avon general practitioners 1978	London* general practitioners 1966	UK* general practitioners 1966	Irish** general practitioners 1968
Delay in getting an appointment	*36.0*	*40.0*	*29.5*	*8.7*
The patients' dislike of being referred	*39.4*	*60.0*	*53.7*	*51.0*
The lack of readily available facilities	*25.0*	*13.3*	*5.4*	*6.0*
Disadvantage of patient being labelled as mental case	*33.9*	*26.7*	*27.5*	*36.2*
Consideration for the busy psychiatrists	*20.8*	*10.7*	*6.7*	*6.0*
The unsatisfactory way patients are dealt with in the clinic	*11.7*	*17.3*	*18.1*	*12.1*
Psychiatrists' delay in sending reports	*4.9*	*5.3*	*5.4*	*14.0*
Lack of satisfactory rapport between psychiatrist and general practitioner	*7.6*	*10.7*	*9.4*	*12.8*
A feeling that the treatment of neurotic patients is the job of the general practitioner	*61.3*	*45.3*	*55.0*	*34.0*

Sources: *Shepherd *et al.* (1966).
**Fahy *et al.* (1974).

Table 5. Levels of significance for those doctors hesitating to refer to outpatients.

Problem	Significance
Delay involved between making the appointment and the consultation	<0.0001
Patients' dislike of being referred to psychiatrist	<0.01
Lack of readily available psychiatric facilities	<0.0001
Consideration for the psychiatrists, knowing how busy they are	<0.05
The unsatisfactory way patients are dealt with in the psychiatric clinic	<0.0001
Lack of satisfactory rapport between me and the psychiatrist	<0.05

Discussion

"It is clear to us that it is now time for an overall assessment of psychiatric services and the resources they should have, into their function in society, the contribution that they should make both within and without the NHS, how much of their skill and time should be devoted to training other workers in the helping professions and to 'counselling', and how much to direct diagnosis and treatment of the very large numbers in the population with serious—not to mention minor—mental disorders. We recommend that this assessment should be undertaken urgently." Hill (1969) ended his monograph *Psychiatry in Medicine* with this quotation from the Seebohm Report (1968). Its urgency is as great nowadays as it was then.

General practitioners in Avon feel that their role in the management of emotional illness is appropriate. They do not refer a large proportion of their patients with such illness to other agencies, be they the various counselling agencies or the psychiatric services. During 1978 psychiatrists in Avon saw about eight new patients for each general practitioner. Some of these patients would have been referred to the psychiatrist by accident and emergency or other hospital departments. Despite this low referral rate a high proportion of general practitioners claim to experience considerable referral difficulties. Their degree of dissatisfaction with the service they believe they get needs further examination as, compared with other specialties, the service given by psychiatrists in Avon is good; patients being seen within a day or two when the situation is 'urgent' and within a month for most routine appointments.

When the factors influencing referral are examined further it is such matters as the lack of readily available psychiatric facilities, the unsatisfactory way patients are dealt with in psychiatric clinics, and the delay between making the appointment and the patient being seen that make general practitioners hesitate to refer.

These reasons cannot fully explain the general practitioners' views. The fact that those doctors who have difficulty in getting outpatient appointments are significantly more often those that agree that "Too often a psychiatrist writes that a patient has improved but when I see the patient I find no change", suggests to us that it is the doctor's attitude to mental illness that makes a large contribution to the difficulties he has with the specialist services.

Hicks (1976) in an excellent review quotes Rapaport's statement that "Mental disorder is the most complex and intractable of man's pervasive ills"; it certainly contributes massively to general practitioners' workloads. Most doctors' training is disproportionately aimed at dealing with physical disease. A proportion of

general practitioners are therefore likely to experience considerable frustration and unhappiness as they try to cope with emotional illness using a physical illness model. Despite the increasing emphasis on management of social and psychological aspects of illness in vocational training schemes for general practice, it is unlikely that all general practitioners will feel confident in dealing with both physical and psychological problems for a long time.

There is considerable evidence that psychiatrists are finding it easier to manage patients that come their way by developing a network of community services including psychiatric community nurses, psychiatric day hospitals, and crisis intervention teams. With many general practitioners believing, as do nearly 25 per cent in Avon, that the care and follow-up of discharged mentally ill patients ought not to be the responsibility of the general practitioner, it is not surprising that these specialist services in the community are increasing as fast as resources will allow. If unchecked this tendency may inevitably slowly exclude the general practitioner from his traditional role as personal physician.

We would like to see this widening of specialist responsibility reversed and agree with Bennett (1978): "For adult patients there are advantages in generalist care: it provides continuity, its approach to mental illness is holistic, it avoids unnecessary 'labelling' and stigma, it bridges the specialties and so prevents fragmentation of care. Finally, it protects the patient from the excesses or narrow mindedness of specialized technocracy."

We therefore see two areas for concern in the management of mental illness at this level: first, the evident difficulties that many Avon general practitioners have at the specialist/generalist interface with psychiatric illness and, secondly, the tendency of many specialists to widen their remit rather than refer patients back to the generalists. That the second will result from the first is not inevitable, for a better alternative, and one that agrees with most other aspects of medicine, is for the two disciplines to work more closely together to improve the knowledge each has of the other and ideally to share training both at vocational and continuing level.

References

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Reimbursement of expenses for higher specialist training

The Council for Postgraduate Medical Education in England and Wales has informed the Conference of Medical Royal Colleges and their Faculties that agreement has been reached with the DHSS with regard to implementation of the following criteria:

1. Expenses of visitors inspecting hospitals for educational purposes should be met by the hospital authorities following agreement of the arrangements for the visit.

2. Expenses of those attending meetings of joint higher training committees and specialist advisory committees and, for those specialties with no joint higher training committee, the college or faculty committees concerned wholly or mainly with postgraduate training should be met in England and Wales by the employing authorities and in Scotland and Northern Ireland by the postgraduate councils.

3. Expenses of those attending regional training committees whose work is closely related to that of regional postgraduate deans—for example, advisory panels, tutors, regional training committees in surgery, regional training committees in the specialties of pathology—should be met by employing authorities.

4. College or faculty committees other than those that come into the categories outlined above should be paid for by the colleges themselves.

It is understood that the comparable councils in Scotland and Northern Ireland have also accepted the criteria.

Reference

Annals of the Royal College of Surgeons of England (1980). Criteria for reimbursement of expenses for higher specialist training. **62,** 250.