General practice and clinical psychology — some arguments for a closer liaison

J. A. KINCEY, B.Sc., B.Phil., A.B.Ps.S.
Senior clinical psychologist, Manchester Royal Infirmary

A closer liaison between general practitioners and clinical psychologists could be of considerable value to the two professions and to patients in the National Health Service. This paper contains four sections. The first of these outlines the professional training and career structure of clinical psychologists. The second endeavours to indicate those skills which the general practitioner might find useful. The third discusses the relative merits of different organisational locations for the clinical psychologist within the NHS, while the fourth section discusses some possible problems of closer liaison.

(1) The training and career structure of clinical psychologists

All clinical psychologists possess an initial undergraduate qualification in psychology, usually an honours degree in psychology, followed by further professional training in clinical psychology, either by a postgraduate university degree (usually two years) or through clinical training and experience within the NHS itself (usually three years). The psychologist who trains in the NHS may or may not have taken the Diploma in Clinical Psychology of the British Psychological Society.

After the completion of this probationary grade training, the psychologist usually takes up an NHS post as a basic grade psychologist, and within the career structure may progress to the grade of senior psychologist, to principal psychologist, and, in a few cases, to top grade psychologist. From the time of appointment as a basic grade, a psychologist can operate independently of the supervision of other psychologists. There are at present about 420 trained psychologists in the NHS with an average annual net increase in occupied posts of between 40 and 50 (British Psychological Society, 1973).

(2) The psychologist's skills

The areas of expertise of the clinical psychologist can be subsumed under two main headings. Firstly, the use of psychological techniques in the individual case and, secondly, the contribution of psychology to more general clinical or organisational research problems.

Table 1 contains an outline and a possible classification of individual clinical problems in which psychologists have been involved and a list of techniques of assessment and intervention which they have used.

The classification used in table 1 is not definitive, nevertheless it provides a framework into which a large number of clinical problems can be fairly readily classified. This it is hoped may be of value as a " shorthand " in terms of which a general practitioner might assess cases for suitability for psychological opinion or involvement.

The second major contribution of clinical psychologists relates to more general problems occurring in the setting of general practice.

It has for example been clearly shown (Ley and Spelman, 1967) that patients often forget a large proportion of the information they receive during a consultation with the doctor. The relationship of such forgetting to anxiety and to the amount and nature of material presented has been established (Ley and Spelman, 1967) and one effective procedure to reduce such forgetting has been suggested (Ley *et al.*, 1973). This area of research will have obvious implications for the general practitioner who often has limited time in which to present information to patients in the surgery.

Related to problems of forgetting are those of non-comprehension of information. Ley *et al.* (1972) have shown how memory for written medical material can be increased by using simpler language as assessed by a formula of readability. Identification of techniques to ensure the adequate comprehension of verbally presented material could be of tremendous importance in general practice.

Satisfaction with the quality of general practice as a whole has been a matter of considerable recent debate (Honigsbaum, 1972; Marson *et al.*, 1973; Sidel *et al.*, 1972; Varlaam *et al.*, 1972). Of particular interest to the psychologist is the problem of satisfaction with communications. Ley *et al.* (1973) have suggested a technique for increasing satisfaction with communications among hospital medical inpatients which stresses the need to ensure adequate comprehension by the patient of what he has been told by the medical staff.

TABLE 1

CONTRIBUTIONS OF CLINICAL PSYCHOLOGY TO CLINICAL PROBLEMS FACING THE GENERAL PRACTITIONER

Categories of problems	*Functions of the clinical psychologist*
Category A Problems of anxiety and stress These may involve patients with any of the following: High levels of ' free-floating ' anxiety; ' panic-attacks'; phobic reactions; anxiety-reducing obsessional ideas or rituals; avoidance of stress situations; psychosomatic illnesses in which stress appears to play an important role e.g. migraine, asthma, essential hypertension.	A detailed assessment of the behaviour and verbal report of the patient and of relevant signs and symptoms. After such assessment, treatment alternatives, if considered appropriate, could be selected from the following: Training in relaxation, with or without the use of physiological monitoring or ' bio-feedback ' information or hypnosis. Specific behaviour-therapy programmes such as systematic desensitization, ' flooding ' or modelling.
Cateory B Habit disorders This category comprises those problems which can, to a useful degree, be construed as maladaptive habits, often endangering physical health and often resistive to change. These include: Smoking; obesity and other inappropriate eating patterns; enuresis and encopresis; addiction to alcohol or other pharmacological agents; tics; stammering; children's behaviour disorders.	Analysis of the behaviour-maintaining reinforcement in the situation will usually be the first step in such problems. Behaviour change techniques based on a variety of procedures might then be introduced. Among others these include: Classical conditioning procedures (positive or aversive) to alter the valancies of relevant stimuli. Operant conditioning procedures to differentially reinforce (increase or eliminate) particular responses, with or without formal self-monitoring of behaviour or feedback of results. Use of attitude change procedures and techniques to ensure adequate comprehension of information, alone or in group situations.
Category C Educational-occupational difficulties or decisions Chronologically throughout the life-span a series of educational-occupational ' choice-points ' or difficulties may occur. If inadequately resolved these may lead to physically or psychologically based presentations in the general-practitioner consulting room.	Psychological information concerning cognitive abilities, aptitudes, interests and values can be used to aid decision-making at significant choice points in life. Training programmes based on the psychological principles of learning and skill acquisition can be used to reduce study problems, or help to train people for new occupations. These procedures should help to reduce the frequency of medical consultation stemming from such origins.

Category D Interpersonal-social-marital problems	
This category comprises those problems in which a marked 'social' element is present, including:	Assessment of these problems would examine the effects of the relevant behaviour on both the individual patient and other key figures in the environment.
Difficulties in social relationships stemming from lack of appropriate social skills, disruptive levels of anxiety or inappropriate patterns of dyadic communication. Sexual difficulties arising from anxiety, ignorance, or guilt.	Intervention, if considered appropriate, might concentrate on the individual alone or also use other, key, figures. Techniques used have included: Teaching of social skills by use of role-playing or 'modelling,' with or without video-feedback of behaviour and either alone or in group setting. Masters and Johnson approaches to sexual dysfunction. Investigation of self-concepts and of perception of roles. The use of contracts between patient and therapist or between patient dyads designed to alter communication and behaviour patterns.
Category E Psychological adjustments to problems stemming from physical illness or other significant life events involving medical care	
Problems in this category might merit either prophylactic or remedial intervention. Examples include psychological preparation of patients for hospital treatment or childbirth and the psychological problems of chronic ill-health, disablement following accident or illness, terminal illness, bereavement, abortion.	Preparation for medical care in patients with disabling levels of anxiety concerning hospitals, surgery or injections could involve any of the anxiety-reducing techniques discussed in category A. Attempts to ensure adequate compliance with antenatal or postnatal care advice could involve the use of attitude and behaviour change procedures. Remedial programmes can be established to maximise the potential of chronically ill or disabled patients such as those suffering from impairment of cognitive functioning after accident or illness. These will often involve readjustment to new roles with changes in 'self-identity' and relationships as well as retraining in cognitive skills. Involvement in counselling at times of crisis (e.g. bereavement) could be useful, probably where inappropriate behaviour patterns are established.

A pilot study in general practice (Kincey *et al.*, 1973) has suggested a high general level of patient satisfaction, but has still indicated some need for attempts to increase patients' satisfaction with communications. The same study has shown a relationship between the variables of satisfaction, comprehension, and patients' ratings of their compliance with advice received from the doctor.

The presence of patient non-compliance with advice is clearly established and widespread. It includes not following dietary advice, failure to stop smoking, failure to take medication as prescribed, failure to carry out antenatal advice, and postnatal care of infants (Ley *et al.*, 1971).

The results of Kincey *et al.* (1973) suggested several important variables involved in non-compliance as reported by patients. These included problems of "will power," economic difficulties, and forgetting or non-comprehension of advice. The further application of psycho-

logical principles to reduce non-compliance and increase satisfaction could therefore be of great value in terms of reducing patient discomfort, demands on doctors' time, and cost to the NHS.

Other subjects of research such as the evaluation of health education procedures or the examination of communication patterns among staff could well involve psychologists where appropriate. Research projects might be specific to a particular practice or have general application to many doctors and with increasing interaction between general practitioners and psychologists new areas of research would almost certainly become apparent.

(3) Where should the clinical psychologist be situated?

Historically, clinical psychology developed in close proximity to psychiatry and neurology with the majority of psychologists working in psychiatric hospitals. During the last decade an increasing number of psychologists have worked in the general hospital undertaking a wide range of work such as that discussed by Hetherington (1967). Even more recently a few community psychologists have been appointed to local government posts and now a very few posts have come into existence within the NHS for psychologists to work in health centres. It is interesting to note however that in the report *Present state and future needs of general practice*, Royal College of General Practitioners (1973) there is no mention of psychologists as members of the health team involved in general practice nor of referrals from general practice to psychologists in a hospital.

In the reorganised NHS many, if not most, psychologists will continue to work in hospital (either general, psychiatric, or sub-normality). Here, they will deal with problems such as those outlined in table 1 and others arising specifically from their position in hospitals. There will always be psychological problems specific to the hospital environment which do not occur in general practice. These include, for example, psychological reactions immediately before and just after major surgery, and problems of patient-nurse relationships on the ward. Psychologists will also continue to be involved closely with particular medical specialties in hospitals—notably psychiatry and neurology.

There are several arguments to suggest that some clinical psychologists could also be usefully employed in geographically closer liaison with general practice, either on a peripatetic basis serving several practices or by attachment to health-centre teams.

By operating at the usual point of first contact between patient and doctor the psychologist should be able to help identify psychological problems at an earlier stage than often seems to happen at present. An example of this is the data supplied by Marks (1969) concerning agoraphobic patients eventually treated in hospital by psychologists and psychiatrists. Among a sample of such patients the average duration of symptoms before the general practitioner became involved was 17 months, and before hospital involvement was 34 months. Such problems could possibly be identified and treated more quickly if psychologists were involved directly in primary care.

There are also compelling theoretical reasons for dealing with problems in the situation in which they arise rather than treating them only in hospital which is so different from the home or work. An increasing number of the techniques of the clinical psychologist involve the parents, spouse, or other key figures in the patient's life. Such people could probably be more easily contacted and effectively involved in therapy in the home than in the hospital clinic, often geographically some distance from the home and involving considerable disruption of their lives.

The prophylactic value of psychological intervention at an early stage in a problem could sometimes prevent hospital being necessary. If programmes effectively modifying behaviour such as helping obese patients to lose weight could become well-established, the possible economic saving in terms of the hospital time and money dealing with the medical sequelae of obesity could be enormous. A similar argument applies to tobacco smoking.

Although as yet untested, the above claims seem to have considerable theoretical importance and should be open to experimental study.

(4) Problems raised by the suggestion of closer liaison

The first problem of closer liaison is that of referral policy. Where the general practitioner refers direct to a psychologist, whether in hospital or within the practice, who assumes responsibility for that patient? In accordance with the British Psychological Society (1973) recommendations, it

seems appropriate that " it is the responsibility of a referring medical practitioner, whether a consultant or a general practitioner, to assure himself that the clinical psychologist is qualified. Thereafter the psychologist is responsible for whatever acts he carries out in treatment, and the referring medical specialist should not be considered responsible beyond the act of referral except insofar as the general practitioner retains primary care responsibilities. The clinical psychologist's responsibility covers all acts which are within his competence. As is the case with all independent professionals, it is part of his competence not to exceed the boundaries of his skills. Where a clinical psychologist and a medical practitioner are jointly engaged in the care of an individual, they should establish by agreement their specific areas of responsibility."

The argument has in the past been advanced that if problems are referred directly to the psychologist rather than to a medical specialist there is a danger that an important medical element in a problem may be missed. This possibility cannot be denied. It must, however, be balanced against two other factors. At present it seems likely that a great number of possible opportunities for contributions by psychologists are missed and that these omissions could often have equally serious, if less acute, effects than could result from the missing of a significant medical element in any problem referred directly to the psychologist. It also seems likely that on occasions a psychologist's intervention in general practice might lead to quicker identification of a medical problem than would occur without such intervention. This might be particularly true in a case where psychological factors were involved in a problem with neurological or psychiatric factors, and where psychological assessment proceedings might highlight these factors.

TABLE 2

POSSIBLE REFERRAL PATTERNS INVOLVING GENERAL PRACTITIONERS AND CLINICAL PSYCHOLOGISTS

Pattern A

The general practitioner refers the problem to the psychologist who reports back to the general practitioner. The problem is entirely a psychological one and there are no other referrals from the general practitioner to medical specialists.

Examples

Patients wishing to stop smoking or to lose weight for health reasons.

Patients requiring advice on educational or occupational problems.

Pattern B

The general practitioner refers a problem simultaneously to the psychologist and to one or more medical specialists (e.g. neurologist, psychiatrist, or paediatrician). Each person receiving a referral reports back to the general practitioner on the relevant aspects of the problem.

Examples

A child with a habit disorder (e.g. enuresis, stutter) in a family setting where parental psychiatric illness is an important factor.

A patient complaining of memory and concentration problems in the work or home.

Pattern C

The general practitioner refers a medical problem to a medical specialist whose report indicates the possibility of a psychological problem arising from the medical one. The general practitioner could then refer the problem to the psychologist who reports back to the practitioner.

Examples

Patients for whom surgery is indicated but whose anxiety about hospital might require some counselling or behaviour modification.

Patients whose medical condition or treatment has necessitated some psychological readjustment or retraining as for example following physical or neurological impairment.

Pattern D

The general practitioner refers a problem to the psychologist whose report back raises the possibility of a medical as well as a psychological element in the problem. The general practitioner might then refer this aspect of the problem to a medical specialist.

Examples

In assessing a patient the psychologist finds test evidence which raises the possibility of either organic impairment of cognitive function or of psychiatric illness. The general practitioner might then feel that this evidence necessitated referral of the problem to a neurologist or psychiatrist.

At present some psychologists employed in hospital do receive direct referrals from general practitioners, although the more usual pattern is still for referrals to come via hospital consultants (British Psychological Society, 1973). The arguments above favour direct access for general practitioners to hospital psychologists as well as to psychologists who might be employed in general practice.

Table 2 describes some possible referral patterns from general practice to psychologist.

Another argument is that some problems ostensibly psychological may still need hospital treatment directed either by a hospital psychologist or by a medical consultant. This situation will undoubtedly occur. Detailed hospital observation and treatment of some habit disorders, for example, may well be essential. Inpatient treatment in hospital or treatment directed by hospital would be particularly likely in cases where psychological and psychiatric factors are both involved. There would be many areas of the psychologist's work which would remain specific to hospitals.

A final area of difficulty concerns the problems of role definition and the possible overlap of skills and interests between psychologists and the other professionals with whom they would work if they operated from general practice. It has been argued that all general practitioners should be aware of the problems of doctor-patient relationships (Browne and Freeling, 1967; Recordon, 1973; Balint, 1972). Some general practitioners will have a particular interest in, for example, relationship problems or other areas outlined in table 1. As such they might choose not to involve a psychologist in these problems, even should one be available. This should prove no problem in that given the range of clinical phenomena illustrated in table 1 it is clear that no psychologist or general practitioner could be a specialist in all of these. Consequently, there will be many areas in which the psychologist could contribute other than those in which the doctor himself was particularly experienced and interested.

Social workers, psychiatrists, health visitors, community nurses and educational psychologists, it can be argued, may feel very strongly that some of those functions listed in table 1 would be within their role and that the clinical psychologist would be overstepping the bounds of his expertise to involve himself in such work. In reply to this argument it seems quite clear that the boundaries of roles are blurred. Examples of this are the increasing involvement of social workers and nurses in behaviour modification techniques (Jehu, 1972; *Nursing Times*, 1973), and the apparent resurgence of discussion between clinical and educational psychologists about their respective involvements in the community. Such blurring can be constructive, even if initially threatening, to psychologists and other professions alike. The gradual expansion of psychologists' contributions in hospital has been possible only through their being able to offer techniques of proven value. Where they have been unable to answer questions their role has not developed.

Exactly the same criteria should apply in the context in which they would work with the other professions outside the hospital. Hopefully, this article has suggested that there are many questions and problems which could be better answered and managed if psychologists and general practitioners established closer liaison.

Acknowledgments

The ideas presented in this paper developed largely while the author was employed as a clinical psychologist in the Doctor-Patient Communication Research Unit, Department of Psychiatry, University of Liverpool, under the direction of Dr P. Ley and supported by a grant form the Department of Health and Social Security. I would also like to thank Dr P. Ley, Mr P. W. Bradshaw and Dr L. Ratoff for their suggestions about the value of formalising these ideas.

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COMMUNICATION BETWEEN DOCTORS

When general practitioners and consultants meet there is often talk of examples of the failure of doctors in hospital to communicate essential information about patients to their colleagues in general practice and *vice versa*. The need to write letters about patients is often a burden, especially if secretarial help is limited.

Nevertheless, clinical care is a shared responsibility between general and hospital practice and any failure to pass on written information about patients promptly is more severely felt now than it was formerly. It is unnecessary to stress the need for continuity in clinical care any longer.

However, there is another need which especially affects general practice and which can only be met by the hospital medical staff. The family doctor should be informed by telephone of the death of one of his patients in hospital. The telephone message should then be followed immediately by a letter giving details, not only for the doctor's personal interest, but the patient's relatives will be in touch with him sooner rather than later, and he should not have to admit ignorance of what has happened.

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