Middle Articles

GENERAL PRACTICE OBSERVED

Psychiatric Care in General Practice: an Experiment in Collaboration

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Patients come to their family doctor with a variety of disorders ; some are in need of psychiatric advice or treatment. Facilities for special care of this kind differ from one area to another : in-patient beds and outpatient clinics are the responsibility of the National Health Service, while in some districts child and family guidance clinics are run as the joint responsibility of regional hospital boards and local authorities. In some places private consultation is available, and may be followed by outpatient treatment or admission to a privately run unit.

However, even where good facilities exist, not all patients are able or willing to use them. Causes for this state of affairs may be: (1) Fear of the psychiatrist and his supposed magical powers or of being thought mad. And looming behind the psychiatrist in the patient's mind may be the image of the hospital for the mentally ill, still thought of by some as a kind of crazy prison. Thus, contact with psychiatrist or mental hospital may seem to the patient to bring with it a much-dreaded social stigma. (2) The patient may be unaware that psychological factors are important in his illness, or he may deny their importance and present to his doctor with physical or psychosomatic complaints. (3) Facilities for psychiatric consultation and treatment are still grossly inadequate, especially where certain types of neurotic illness are concerned. Waiting-lists at child guidance clinics may be so long that when help is finally offered it is no longer usable or required. In adult outpatient clinics and departments there is frequently inadequate time for the individual patient. Intensive psychotherapy, as distinct from chemotherapy or supportive therapy, is rarely available outside the medical teaching centres or private consulting-rooms.

The scheme we are about to describe has as its aim the provision of psychiatric diagnosis and psychotherapy as part of the family doctor's service, to be available where patients have not been able to use other help. It has also aimed to create a much closer working relationship between the family doctor, the specialist, and the psychiatric social worker.

Nature of Practice

There are five general practitioners working in a group from central premises. The practice is in Winchester, and includes National Health Service and some private patients ; it is both urban and rural, and members of the group hold appointments in schools, remand homes, H.M. prison, and an area hospital. The partnership already has a health visitor, midwife, and district nurses attached. Child welfare, inoculation and vaccination, and antenatal and post-natal clinics are held on the

premises, films are shown, and an appointment system has been in existence for several years.

Each doctor, so far as is possible, sticks to his own patients—any treated by the duty doctor being handed over the next morning. Each partner also has his particular interest, ranging through dermatology, E.N.T., physical medicine, and adolescence. The partners work closely together, and have a common-room and small library. The aim is to build up a comprehensive team of doctors with a *trained* medical and non-medical ancillary staff, all working together to treat and care for one group of patients from one set of premises.

For some time the practice has felt the need for the attachment of a full- or part-time psychiatric social worker, but so far this has not been possible. The idea was then mooted of asking one or two psychiatrists if they would support, purely in an honorary capacity, a scheme whereby they would see certain selected patients in the general practitioners' rooms—usually and necessarily at inconvenient hours so that the patient's normal working day would not be interrupted or embarrassed. The scheme was to include regular seminars attended by all the doctors concerned, at which a programme of treatment would be elaborated and follow-up discussions would be possible. This suggestion was readily accepted by two consultant psychiatrists (one man, one woman), who were both engaged in nine sessions per week for the National Health Service and who undertook a very small amount of private work from their own consulting-rooms. Latterly a third consultant psychiatrist has joined the group ; he, too, works for the National Health Service. He is on the staff of a nearby psychiatric hospital and is the regional tutor in psychiatry. A psychiatric social worker (also honorary) has been part of the psychiatric scheme from the beginning—she had previously been working in child guidance clinics, and is now engaged in full-time university teaching.

Organization of Work

Rooms for the psychiatric scheme are available in the family doctors' surgery. Some of the rooms are furnished as consulting-rooms without surgical equipment, and are specifically designed for the use of attached ancillary staff.

Appointments are made through the surgery's secretary, who also attends to any correspondence which may be required in connexion with the treatment of a patient.

The selection of patients is made in the following way. Some of the patients seen by the general practitioner in his consulting-room are thought to be in need of psychiatric investigation or treatment. If the general practitioner feels that a patient cannot

wait several weeks for an appointment, tolerate a journey to a distant clinic, or the uncertainty of having to see different doctors at different times, he would consider such a patient suitable for referral.

Further, the general practitioner may believe that a particular patient will benefit from his own continuing support and care, along with that of his psychiatric colleague.

Thirdly, if the case seems to be one in which a more intimate investigation of the family background is necessary, the family doctor would want to join with the psychiatric social worker in doing this work.

Psychiatrist's Work

Diagnosis.—The referring doctor of the practice contacts the psychiatrist, and the medical notes are made available and may be amplified by discussion. After a first interview—or if necessary more than one—a tentative diagnosis is made by the psychiatrist, a discussion ensues with the family doctor, and a practical plan of treatment is evolved.

Psychotherapy.—The length of treatment and the spacing of the interviews are dependent on the individual patient's needs. Usually, when long-term treatment is planned, patients are seen for an hour's session once a week. During periods of crisis two sessions may be needed. The patient's home circumstances and the demands of his work may limit the scope of treatment, and if the patient should require admission to hospital he would pass out of the care of the group.

In selecting patients for intensive psychotherapy the psychiatrist tries to assess the individual's ability to hold out in between sessions, and in this scheme there is special support available from the patient's own doctor. This ability to tolerate tension and contain anxiety is an important factor, especially as the psychiatrists are able to give only a limited amount of time to the scheme. Thus a strong relationship with the family doctor is a necessary and adequate safeguard.

Role of the P.S.W.—The psychiatric social worker has functioned in a traditional way—that is, she has contributed to a fuller and more accurate diagnosis by the taking of a family and social history, and she has provided casework help to members of the patient's family, thus reinforcing the therapeutic plan. This latter is achieved by focusing on a key relationship in the patient's environment and by attempting to modify this by furthering his knowledge and insight, and by the confrontation with reality.

The psychiatric social worker also supports the psychiatrist by tackling some aspect of the patient's difficulties from another angle. She has, too, been able to help the team to see that the patient's difficulties may be symptoms of a larger pathological process involving the whole family.

Role of the Family Doctor.—The family doctor helps with support to the patient as part of the plan of treatment or in an emergency, and he is able to prescribe and supervise the drugs which may be necessary. He can also support the psychiatrist where the patient's physical complaints are a source of uncertainty or anxiety.

Case Discussions.—These meetings have taken place every six to eight weeks—though during the early period, the winter of 1964–5, they were held less often because of the pressure of work on the general practitioners.

The meetings take place in the group's common-room at 8.30 p.m. and may last for one and a half to two hours. During the meetings the psychiatrists have reported on the cases seen for diagnosis, or on the progress of those in treatment. Discussion has followed, allowing for the plan of treatment to be renewed, for a new approach to emerge, or for other members of the team not hitherto connected with the case to be drawn in.

As the group became more familiar with the meetings other cases were brought up for discussion—and problems were raised

and ventilated—without the psychiatrist actually seeing the patient at all. So the group's advice and support became available for any of its members in their handling of difficult cases or situations, and much more flexibility in the pattern of consultation was possible.

In these informal meetings freer communication between us has created an atmosphere from which a deeper understanding of the patient and his problems has undoubtedly emerged. The group has thus grown into a therapeutic team which gives support and promotes learning by the sharing of anxiety and knowledge.

The closer work with family doctors has led to a great gain for the psychiatrist, who not only keeps a link with general medicine but also benefits from the family doctor's experience of the patient and of his family over the years. Thus, apparently minor details about complaints have been brought into the open, and the discussion has often resulted in an appraisal of the patient's history and condition which is rich in detail and full of immediacy.

Case Reports

The following cases were seen during the period September 1964 to January 1966.

1. A girl, aged 16 years, was referred for failure in school work and withdrawal. Her symptoms included sleepwalking and over-breathing. She was diagnosed as an anxiety state with hysterical features. Intensive psychotherapy was carried out with the patient, and the P.S.W. saw the mother. The family doctor maintained contact with the school. The outcome was a successful resumption of schooling and the beginning of training for a career. Relationships improved all round.

2. A married woman, aged 28 years, with one young child complained of loneliness and fits of crying. The diagnosis was puerperal depression. Brief psychotherapy was given, with complete resolution of symptoms.

3. A married woman, aged 46 years, with three children complained of insomnia, apathy, sadness, and withdrawal. A climacteric depression was diagnosed, and brief psychotherapy given with support by the family doctor. The symptoms resolved, but she relapsed later.

4. An unmarried woman, aged 37 years, gave a long history of depression with psychosomatic symptoms, and complained of fugel states and tiredness. The diagnosis was emotional immaturity, a chronic anxiety state, and depression. She was treated by intensive psychotherapy with strong support by the family doctor. There was a slow gain in security and diminishing fugel states. Treatment is continuing.

5 and 6. Two girls, aged 14½ and 13½ years, who were living with foster parents and attending day school, were referred for lying and stealing. Emotional deprivation was diagnosed, and supportive interviews with foster parents and children were given. A consultation was held with the welfare officer of the Children's Society. The situation improved temporarily, but later broke down, and a new placement was advised.

7. A girl of 15 years lived at home and attended school. She was somewhat withdrawn, with confused thoughts and physical symptoms. She was diagnosed as an anxiety state with schizoid features. Intensive psychotherapy was given, with significant improvement. Supportive interviews are continuing.

8. A single man, aged 38 years, from a cultured background and with a professional occupation, was referred by others because of his eccentric and excitable behaviour. There was a history of previous breakdowns. He was diagnosed as paranoid schizophrenia. Supportive psychotherapy was given, with additional tranquillizers. The family doctor kept in touch with the employers, and successfully reassured them. As a result of treatment the patient's equilibrium was restored and his professional life remained intact. Support is continuing.

Conclusion

This scheme can help patients by offering the possibility of early diagnosis, and, if required, psychotherapy of a kind

usually available only in private practice. It is obvious that such an arrangement can be made available to only a small number of patients, and that it should be reserved for those who would otherwise suffer from lack of the necessary help. Certain conditions need to be fulfilled: (1) a group practice of family doctors working together; (2) suitable premises and ancillary services; (3) the availability of psychiatrists who have experience in intensive psychotherapy, including psychoanalysis, and who are used to working with both adults and children; (4) the availability of a psychiatric social worker who has wide experience.

The advantage to the patient is that therapy is adapted to his needs. He can meet the specialist in familiar surroundings, introduced by his own doctor. There is no waiting, and he is not subject to the pressures of the outpatient clinic. Enough time is available for him. But he has to accept also that he must hold out between sessions, if necessary with the support of his own doctor. The surgery provides a safe setting, and the patient can get on with his treatment without coming under the scrutiny of strangers. The psychiatrist also feels safer. He has a colleague with whom to confer over the physical aspects

of the case, and the patient cannot, willingly or no, so easily play one doctor off against the other. Easily available beds for short admissions might also add scope to the scheme. One of the obvious and most important advantages is that diagnosis and treatment may take place without delay. This may be of particular importance where serious disorders are suspected, or in cases of severe reactions to loss or bereavement. The effective work of the team may make admission to hospital unnecessary. A great deal of the family doctor's time may be saved if certain chronic patients can be helped into a more active treatment situation with someone who has more time available.

From the point of view of all the doctors and the psychiatric social worker the development of the team, with its helpful and informative case discussions, has been a rewarding experience. The pleasure of working in friendly cooperation contrasts sharply with the usual hasty contacts by letter or by telephone. Thus the patient has the benefit of better treatment, and the doctor gains increased satisfaction.

The team regards the scheme described as a successful experiment.

ASPECTS OF POSTGRADUATE MEDICINE

II.—Chelsea Postgraduate Medical Centre

[FROM A SPECIAL CORRESPONDENT]

Many harsh words have been written about the delay in building the Postgraduate Medical Centre at Chelsea.¹⁻³ Matters have been brought to a head with the resignation of the project director, Mr. Brian Langslow, on 22 April, who was reported as saying, "My job is to plan hospitals which are going to admit patients, not merely to plan plans."³ In response to press inquiries the Ministry of Health issued a statement, which is printed at the end of this article.

History

Several factors highlighted the shortcomings of some of the smaller London postgraduate teaching hospitals once they became incorporated into the British Postgraduate Medical Federation: the rapid progress of medicine; the introduction of the National Health Service; and the demands made by an expanding programme of teaching and research. Besides being small, many of them are scattered—so that at the Institute of Dermatology at St. John's Hospital eight miles separates the outpatient department in Leicester Square from the wards at Homerton. Their facilities are insufficient—so that, for example, two x-ray departments serve the three special urological hospitals. They are situated mainly in Central London, where traffic congestion makes access for both doctors and patients difficult and there is little or no room for expansion.

On 21 June 1961 Mr. Enoch Powell, who was then Minister of Health, made a statement in the House of Commons. He

said that, though several of the special postgraduate hospitals and institutes should not be moved, others should be brought together in two groups. One of these was to be in the Holborn area; the other was to be related to the Brompton and Royal Marsden Hospitals in Chelsea. A committee would be set up, Mr. Powell continued, to advise on the advantages of this proposed grouping. The committee's report—now usually known as the Pickering Report, after its chairman—was published 15 months later.⁴ It visualized an ideal association of special hospitals and their attached institutes as comprising between four and six of them grouped round the periphery of a circle. Though each would have retained its own identity, wards, operating-theatres, staff, and research departments, some

Planning office on part of the site for Phase 1.

(Barratts)