A Survey of Psychiatric Care in Family Practice

Charles K. Smith, M.D., John C. Anderson, B.A., Minoru Masuda, Ph.D.

Seattle, Washington

Information on some of the psychiatric aspects of their practice was obtained from 141 randomly selected family physicians currently in practice in Washington State. Ninety-six percent of these physicians felt that their role included management of their patients' emotional problems. Most felt that 20 to 30 percent of their patients had significant emotional problems, and the physicians surveyed spent an average of 26 percent of their time dealing with psychiatric problems. Most patients requiring psychiatric attention initially presented with physical complaints; less than 15 percent presented with a psychiatric complaint. A wide variety of resources was used in handling the emotional problems seen. Over half of the physicians had participated in postgraduate programs or courses in psychiatry. Fifty-five percent regularly read psychiatrically oriented journals or periodicals. Limitations perceived in psychiatric care given in a medical setting included time, cost to patients and inadequate training.

Family physicians spend a large amount of time dealing with emotional problems. Excellent training is needed in this area to allow family physicians to handle these problems with a maximum amount of efficiency to their patients and to themselves.

In planning training programs for family physicians, it is important to know what practicing physicians do. We are particularly interested in the behavioral science area and, therefore, wished to know what family physicians do to care for their patients' emotional problems.

To study this, we designed a questionnaire which we felt would provide information on how family physicians perceived the psychiatric aspects of their practices. We requested information on how much time they spent with these problems, how they handled them, how adequate they felt their training was, and finally, what their limitations were.

From the Departments of Family Medicine and Psychiatry, University of Washington School of Medicine, Seattle, Washington. *This work was supported by the U.S. Public Health Service Undergraduate Training In Psychiatry Grant No. 5-T-2-MH-5939-22, by the National Institute of Health General Research Grant No. 5-SO1-RR05432-10, and by the O'Donnell Psychiatric Research Fund. Parts of this study were presented at a scientific session of the Society of Teachers of Family Medicine in Miami, Florida, November 6, 1972.* *Requests for reprints should be addressed to Dr. Charles K. Smith, Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington 98195.*

Methods and Materials

Information was gathered from questionnaires that were sent to a representative group of practicing family physicians. This group, selected by random methods, consisted of one-third of the physicians in Washington State listed as general practitioners or family physicians. Lists were obtained from both the Washington Academy of Family Physicians and from the Office of Continuing Medical Education at the University of Washington School of Medicine.

Of those physicians who did not return questionnaires, one-fifth were randomly selected and interviewed by telephone. This enabled us to evaluate differences between the "responder" and "non-responder" groups of physicians.

The questionnaire consisted of 32 items. The main questions were concerned with practice location and arrangement, length of time in practice, perceived prevalence of mental illness among patients, time spent with patient's psy-

chiatric and emotional problems, perception of limitations on psychiatric care provision, training in psychiatry, and utilization of referral and consultative resources. *Psychiatric problem* was defined in the questionnaire as, ". . . any mental, psychological or emotional impairment which calls for some sort of professional attention . . . ," and *psychiatric care* as, ". . . such professional attention as provided either by the family physician or by some referral person or agency."

The questionnaire results were coded for computer analysis; tabulations, calculation of mean, median and standard error values, and cross-tabulations were done using the Control Data 6400 facilities of the University of Washington Computer Center.

Results

Questionnaires were sent to 401 physicians, and responses were received from 158 (40 percent). Of those responding, two returned uncompleted questionnaires, and 15 were no longer in active family practice. The following results were derived from the responses of the remaining 141 active family physicians who completed questionnaires.

The average time in practice was 21.6 years, with a range of five months to 48 years. A majority, 74 (52.5 percent), were in solo practice; 43 (30.5 percent) had one or more partners, and a further 19 (13.5 percent) were members of multi-specialty groups. Seven of the physicians held D.O. degrees, and 134 held M.D. degrees; 96 (all M.D.s) were members of the American Academy of Family Physicians. A large proportion of the physicians were located in metropolitan areas; distribution by town size is shown in Table I.

Acceptance of a role as provider of psychiatric care was explored. When asked, "Do you consider the diagnosis and management of psychiatric problems to be part of your medical role?" 136 (96.5 percent) answered affirmatively.

Several sources of training and knowledge in psychiatry were reported. Twenty (14.2 percent) of the physicians had had psychiatry experience in a residency training program. Seventy-one (50.3 percent) reported attending postgraduate courses or programs in psychiatry, and 78 (55.4 percent) reported regular reading of psychiatry-oriented journals and literature. Other reported learning experiences included working contacts with psychiatrists and other mental health workers.

When the physicians were asked to describe the psychiatric aspect of their practices, 101 (71.6 percent) reported that between 20 and 30 percent of their patients had "significant mental, psychological or emotional impairment of some sort;" 21 (14.8 percent) felt that less than 20 percent of their patients had such problems, and 13 (9.2 percent) estimated more than 30 percent.

The amount of practice time spent with patients' psychiatric problems was studied; an average of 26 percent of a physician's practice hours were spent dealing with these. Twenty-seven physicians (20 percent) reported spending

TABLE I

Distribution of Physicians According to Population of Practice Location

	Population Range				
	Less than 5,000	5,000-15,000	15,000 30,000	30,000 60,000	More than 60,000
Number of Physicians	22	21	20	15	63
Percentage of Physicians	15.6	14.9	14.2	10.6	44.7

TABLE II

Presenting Complaint of Patients with Psychiatric Problems

Given the categories shown in the table, physicians estimated what percentage of their patients with psychiatric problems presented in each way.

Type of Presentation	Mean of Reported Percentages
A. Patient presents to you with chief complaint of a psychiatric problem.	14.3%
B. Patient presents with physical complaint, with associated emotional or psychiatric problems.	56.6%
C. You observe patient's behavior to be unusual or abnormal, unrelated to physical problem.	14.9%
D. Patient's family or friends bring problem to your attention.	11.0%
E. Previous or referring physician describes the problem.	2.5%
F. Other	0.7%
	100.0%

more than 30 percent of their practice time with psychiatric problems.

The physicians were asked to indicate how these patients presented initially. Their response to this question is shown in Table II. It is apparent that the most frequent type of presentation is when the patient comes in with a physical complaint but has an associated emotional problem. The physical problem is the "ticket of admission" with which most family physicians are intuitively familiar.

The physicians utilized a variety of mental health care resources in managing their patient's psychiatric disorders. Mean frequencies of use are shown in Table III, along with the range of the values obtained for each item.

Limitations on psychiatric care provision were investigated. Physicians were asked to rate each of six suggested limiting factors on a scale of one to four, with "4" denoting greatest importance, and "1" least importance as a limiting factor. The distribution of responses to each item is shown in Table IV. It is apparent that time limitation is perceived as the greatest limiting factor.

Of the 243 physicians who did not return questionnaires, 49 were selected for telephone interviews. Of these, four were in active practice but were unavailable for an interview, and 16 were no longer in active family practice. The other 29 were interviewed using selected items from the questionnaire. Their responses are shown in Table V with the corresponding results from the initial "responder" group. The similarity of responses is quite strong between the two groups indicating that we had a representative population and that the physicians who returned this questionnaire were not, as a group, biased with respect to the psychiatric aspects of their practice.

Discussion

The magnitude of the psychiatric aspect of family practice is demonstrated by our finding that the majority of these physicians acknowledged psychiatric problems, as defined above, in 20 to 30 percent of their patients and spent a average of 26 percent of their time dealing with these problems. Some previous studies have produced lower estimates. Locke and Gardner found that 16.9 percent of adult, white patients of general practitioners and internists had psychiatric problems diagnosed by the physician.[1] Mazer found that 5.2 percent of the people in a study population had consulted family physicians in the area for "significant psychiatric disorders."[2] Gardner estimates that between six and ten percent of family physicians' patients have "formal psychiatric disorders," with a further five percent having ". . . other psychiatric symptoms or emotional disorders."[3] The disparity among these values probably reflects the different criteria used by different investigators, as well as differences in methods and populations.

The amount of physician time spent with patients' psychiatric problems is appreciable. Our finding that 26 percent of practice time is occupied with psychiatric care is in agreement with both Auken's report of Danish general practitioners, which estimated 25 to 30 percent of practice hours to be psychiatrically directed,[4] and with an American Academy of Family Physicians' study, which found that among member-physicians surveyed about one-fifth of practice time was spent ". . . counseling patients for emotional problems."[5]

The near-unanimous acknowledgment by the physicians in our study of the diagnosis and management of psychiatric problems as part of their role differs somewhat from previous findings. When two groups of non-psychiatric physicians, including family physicians, in New York City and Portland, Oregon, were surveyed, it was found that ". . . these physicians did not consider their medical role to include the management of emotional disorders."[6] Others have found that compared to other physicians ". . . the general practice group saw their roles more in terms of treatment of emotional problems. . . ."[7]

The high frequency with which our respondents reported that patients having psychiatric disorders presented with physical complaints (see Table II) agrees with Locke's and Gardner's finding that most patients with psychiatric problems may come in with a physical complaint or for an apparently routine examination.[1] Also, the fact that family members or friends alert the physician to a patient's psychiatric problem may illustrate the advantage of close contact with the family unit.

We have commented on some aspects of the training of family physicians in the behavioral sciences. As noted above, only 14 percent had psychiatric training in their residencies. In Table IV, it is seen that many family physicians felt that inadequate training limited their role in providing psychiatric care. Other authors have noted frequent physician dissatisfaction with medical school training in psychiatry.[5,6,8] The need for additional training is reflected in the relatively high number in our population who take postgraduate courses in this area (52 percent), and who regularly read psychiatry journals or related materials (55 percent). It is of interest that other researchers have not found that a high percentage pursue postgraduate training in this area.[9] The need to incorporate training in the behavioral sciences at the residency level has been increasingly recognized, and a strong emphasis is being given to this area in the University of Washington Family Practice Residency.

In regard to factors which the physicians perceive as limiting their own psychiatric role (see Table IV), as we noted previously, the time factor was seen as the most important limitation. Other investigators noted that the pressure of other patient care needs made it difficult for the physician to give adequate attention to the emotional problems of their patients.[8,10] There may also be other factors involved in the perception of time limitation. It may be, for example, that the time factor is seen as a problem because treatment of emotional disorders is seen as requiring a great amount of time; in *many* cases a briefer intervention would be effective. More training in the behavioral science area would be expected to increase physician comfort, allow more efficient intervention, and permit a wider range of treatment strategies.

TABLE III

Frequency of Use of Mental Health Care Resources by Family Physicians

Suggested Resource	Number of times used per year	
	Mean	Range
A. Direct consultation with a psychiatrist	11.29	0 to 100
B. Telephone consultation with a psychiatrist	8.92	0 to 65
C. Referral of patient to a psychiatrist	15.64	0 to 100
D. Referral to community mental health program	11.66	0 to 100
E. Hospitalization for psychiatric problem	6.23	0 to 30
F. Referral to clinical psychologist	4.56	0 to 100
G. Referral to clergyman	4.36	0 to 50
H. Other resources* used	1.08	0 to 60

**Other resources reported include psychiatric social workers, crisis clinics, family counseling services, and alcoholism referral centers.*

TABLE IV

Limitations on Psychiatric Care Provision by the Family Physician

For each suggested item, the table shows the number of physicians marking each level of limitation, with "4" denoting greatest and "1" denoting least limitation.

Suggested Item	Degree of Limitation			
	4+	3+	2+	1+
A. Reluctance of patients to seek or accept physician's help for psychiatric problems	11	25	60	41
B. Excessive cost to patient of required therapy time	28	30	41	38
C. Inadequacy of physician's training in psychiatry	18	32	60	27
D. Personal preference to avoid involvement with psychiatric care	11	18	55	53
E. Time limitations of medical practice	65	45	17	10

In general, the physicians in our study did not endorse "personal preference to avoid involvement with psychiatric care" as an important limiting factor. In contrast, Hoffman, reporting on a practice-based study of general practitioners, states "83 percent of the physicians seemed either indifferent or uneasy when faced with psychological problems".[8] Ehrenwald and Kloth, working with general practitioners in a psychiatry training program, suggested misconceptions of mental illness to be a major limitation for many of the physicians.[11]

In addition to their own intervention, the family physicians in our survey used a wide variety of mental health care resources (see Table III) in managing their patients' emotional problems. The wide range in use may have been largely due to varying resource availability in different areas, but this was not assessed in our study. In one study of urban general practitioners, an average of 2.7 patients per month were referred to psychiatrists.[12] Hyams, studying a group of

TABLE V

Comparison of Responder and Non-responder Groups on Selected Questionnaire Items

Item	Result from Responder Group	Result from Non-responder Group
A. Years in practice, average.	21	28
B. Percentage of patients with psychiatric illness: percent of physicians agreeing with estimate given.	71.0%	90.0%
C. Consider psychiatry as part of role: percentage answering "yes"	96.0%	90.0%
D. Mean number of psychiatric referrals per year	15.64/yr.	20.34/yr.
E. Percentage of physicians in town size of:		
1. less than 5,000	15.6%	16%
2. 5,000 — 15,000	14.9%	10%
3. 15,000 — 30,000	14.2%	10%
4. 30,000 — 60,000	10.6%	12%
5. Greater than 60,000	44.7%	52%

rban non-psychiatric physicians, found that 31 percent re-erred less than three percent of their patients, and 33 per-ent referred four to six percent of their patients to psychia-ists.[6] He also found that more than 60 percent of the phy-icians used other resources (community clinics, social gencies, mental hospitals, clergy, and youth centers) either rely or not at all.

Several reasons have been suggested for the apparent in-equency of psychiatric referrals by family physicians. It has een suggested that this in part is due to the unwillingness f psychiatrists to communicate effectively with the refer-ng physicians.[12] Language differences between psychia-ists, distrust of each other's relationships with patients, and iffering expectations with regard to therapy may all con-ibute to the reluctance of family physicians to refer more atients.[13]

In summary, the family physicians who were surveyed ppear to be generally aware of their patients' needs for sychiatric care and to see the provision of such care as part f their roles. However, they also see their involvement in is role limited by the pressures of practice oriented oward physical illness. It is our feeling that increased un-erstanding of emotional disorders will enable family physi-ians to recognize the importance of their intervention of atients' emotional problems as critical and will also en-ance their role as a practitioner of comprehensive care.

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