Medical Practice and Psychiatry: The Impact of Changing Demands

formulated by
the committee on public education

Group for the
Advancement of
Psychiatry

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The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health in good human relations.

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MEDICAL PRACTICE AND PSYCHIATRY: THE IMPACT OF CHANGING DEMANDS was formulated by the Committee on Public Education.* The members of this Committee as well as all other Committees are listed below.

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* This report is sixth in a series of Reports and Symposiums which will comprise Volume V. For a list of other GAP publications on topics related to the subject of this report, please see page 379.
between patients and their physicians are the keystone of medical practice.

Patients Expect Relationships with Physicians

Medical skills and the efficacy of medicines are greater now than ever before. Yet patients express a regret for the passing of the “good old days” in which, as one physician said, “The doctor sat around all night holding the patient’s hand and watching him die.” There is definite evidence that the public expects physicians to meet the emotional needs of patients; every patient wants to be able to “tell his troubles” to the doctor of medicine to whom he turns for help. Tangible expression of this expectation occurs in the replies to a questionnaire evaluated during the Conference on Psychiatric Education held in 1951 in Ithaca, New York. Implicit in these replies was a “predisposition to think of the physician as having key responsibility in meeting these (emotional) needs, to hold him accountable for not so doing and to believe that his training is lamentably lacking insofar as it fails to provide him with the means to help solve these problems.” The Report of Preparatory Commission I of the Conference discloses that five and one-half times as many respondents to the questionnaire thought that physicians in general were not helping with emotional needs as those who thought they were.9

A common complaint is: “My doctor is so busy I never have a chance to sit down and have a really good talk with him.” Medical practitioners are aware of this professional shortcoming and are actively seeking to remedy it. The American Medical Association began to seek ways and means of implementing a program designed to alter organized medicine’s stance vis-à-vis the emotional aspects of disease and health at its 1962 Congress on Mental Illness and Mental Health. Similarly, many articles and books have appeared during the past decade with the thesis that the general physician does not sufficiently consider his patient’s emotions.

Some authors have contended that the process of medical education “trains the humanity” out of the physician by focusing interest and attention on the physical components of illness and the techni-
Both Physicians and Patients Experience Frustrations in Their Expectations

One of the main issues concerns the extent to which "treating the whole person" is irreconcilable with excellent medical care. A concomitant of technical proficiency is overspecialization and resulting fragmentation of care. The conflict between the two is exaggerated by the discrepancy between the number of medical cases and the physicians available to treat them.

The medical manpower shortage means that time must be sacrificed in treating individual cases; this in turn results in physicians' dispensing with "bedside manner," "hand-holding," and other practices whose omission makes the patient feel that the doctor is emotionally divorced and rendering impersonal care. He thus concludes that, since the physician does not care about him, he is in medical practice for reasons of financial gain and prestige, rather than for humanitarian ones. Having previously overvalued the physician, the patient experiences disappointment that leads to subsequent devaluation, and the physician is seen as unsatisfactory.

Difficulties deriving from confusions and conflicts of expectations and values are closely related to changes in man's views of human nature. His orientation is becoming increasingly introspective, with an increasing awareness of the irrational forces operating within himself. But this approach is a relatively recent one. The traditional emphasis on rationality is reflected in medicine's assumptions and practices. Medicine has always been active and directive, dedicated to manipulation and tangibility of symptoms, treatment, and care (in a relationship of cause and effect) and has assumed the existence of definite questions and answers. Current medicine, with its emphasis on improved techniques, is still moving in this direction. Physicians are oriented toward the natural sciences, toward what is observable and physically measurable, predictable, knowable, controllable—to toward concrete and specific action. Their orientation is toward objectivity, and they rely on clearly formulated diagnostic and treatment procedures and modes of action that are directive and authoritative.
II.

DIFFERING VALUES WITHIN MEDICINE

In interviews with 90 nonurban general practitioners, Taylor asked what the physician would do with eight emotionally disturbed patients described in a brief clinical history. The general practitioners' responses were then compared with those of 71 psychiatrists. The comparison showed that both the psychiatrist and the general practitioner are bound by their traditional roles and their patients' expectations. The general practitioner, oriented toward concrete and specific actions, relies on clearly formulated diagnostic and treatment procedures. He and his patient focus their attention on physical problems, and he relates to his patient primarily in a trusting, tender, and blunt manner. Taylor concludes that "techniques useful to the general practitioner may not work for the psychiatrist operating in a much different role. Psychiatric skills may even be maladaptive for the general practitioner." In this connection, Hawkins comments that "certain subtle role differences between psychiatrists and other physicians may have an important divisive effect." He notes that nonpsychiatric physicians become stereotypical and may become so directive as to give advice in matters that do not concern them.

For physicians other than psychiatrists, illness traditionally represents a distinct episode in a patient's life. The physician uses a fine-tooth comb to seek the disease. Having heard the presenting complaint, the physician conducts a question-and-answer session; then he gives the patient a physical examination and does laboratory studies. Trained to control or minimize disease, he ordinarily has little interest in the panorama of the patient's life or psychological behavior, except as they reveal possible etiology. Even during treatment the patient customarily is relatively passive. The general physician rarely, if ever, relinquishes his traditional authoritative, directive, active role during treatment.

It is little wonder that a general physician accustomed to this approach should have difficulty understanding the approach of the psychiatrist. He may feel estranged from the physician who attaches etiologic significance to nonphysical forces, who not only listens to whatever the patient has to say but even encourages the patient to report whatever thoughts come to his mind, who interests himself in seemingly irrelevant aspects of the patient's life and speech, who exhibits no compelling need to keep his patients on a rigorously prescribed regime, and who in fact asks the patient to take the initiative and not to depend upon the physician for advice and direction.

In its Final Report, the Joint Commission on Mental Illness and Health observed that the "bulk of young energetic doctors . . . turn to areas and techniques in which they believe they can do something tangible for patients or otherwise satisfy themselves in careers as teachers and scientists." There is much evidence that both the student physician and the practitioner are attracted by medical activities that provide an opportunity to "do something" tangible for patients. Medical writers report that the general physician, in addition to being directive and organic in orientation, is preoccupied with the concrete and inclined to disparage himself unless he does something specific.

The scientific orientation is the Rome from which many roads lead. It impels the physician to overprescribe rest, vacations, sedatives, and other medications. It stampedes the doctor into "doing something — just anything." It propels him into advice-giving and ultracautious medical counseling. Maurice Hyman therefore urges his fellow physicians not to argue and not to advise. The most significant outgrowth of the medical orientation is the inner conviction that unless one gives the patient something (medication, a rest, a diet, an incision, an appliance, advice, or directions), one is not treating him adequately. Since many patients expect "gifts,"

the attitudes of the doctor thus oriented and the needs of a sizable group of patients are complementary. Unless this expectation is understood, there may be a loss of further interest in psychological phenomena.

III.

THE NATURE OF MENTAL ILLNESS

Man’s desire for order, for control over the universe (and himself) is consonant with the active, directive, controlling characteristics of medical practice. His fear of disorder and loss of control makes him reluctant to involve himself with psychiatry’s concerns, and especially with mental illness. The myth of mental illness is that it is just like physical illness. In fact, it differs in several important ways. It represents an extreme of loss of control, which most people find very threatening. It is often disruptive and therefore socially intolerable. The Joint Commission on Mental Illness and Health has indicated that, unlike physical illness, mental illness often does not arouse sympathy; on the contrary, it produces anxiety and avoidance.

Unlike most physical illness, emotional conflicts and psychological defects are usually of long standing and are influenced by unconscious factors that are not readily observable. They are constantly interrelated with environmental factors, and are changed in various ways by patients’ attempts to defend against the fears and anxieties they engender. Occasionally treatment is effected by change in environment, that is, a shift in personal relations or reduction of capacity to react to them by use of sedatives or tranquilizers. But, in general, favorable change of a lasting nature is brought about by intricate processes of interaction between patient and therapist that result in increased understanding by the patient of the nature of his difficulty and some effective way of approaching a solution.
IV.

THE NATURE OF PSYCHIATRY

Psychiatry is presently undergoing a vast change in concepts and methods. Until the last few decades it has been concerned almost exclusively with the study and treatment of abnormal behavior. Gradually it has become apparent to psychiatrists that abnormal behavior cannot be properly understood unless the conditions that govern those who do not become ill are also known. Of necessity, the boundaries of psychiatry have enlarged to the point where everything human is relevant; yet the essence of psychiatry remains the task of understanding and minimizing those actions, thoughts, and feelings that interfere with optimal functioning. In other words, its interest lies primarily in how and why men fail to achieve that of which they are capable.

Psychiatry is not a systematic philosophy. All psychiatrists make certain assumptions about men: that he is neither inherently good nor bad at birth but has enormous potentialities for either; that his behavior can be understood; and that he can determine in large measure whether he is to be basically good or evil, effective or ineffective, constructive or destructive. In working under these assumptions a wide variety of philosophic views may be utilized.

Psychiatrists do not necessarily look upon "perfect" adaptation to one's environment as indicative of good emotional health. Certainly adaptation to humiliating conditions in a passive dependent way is not desirable, especially when the course renders the individual ineffective and deprived of satisfaction from his life and work. But under certain conditions, such as concentration camps, this may be desirable. Constructive rebellion or refusal to adapt to un-

acceptable situations may be the essence of good emotional health; sometimes even death may be, if the individual's value system experiences death as a maintenance of self.

Psychiatry has traditionally concentrated on a microscopic view of the problem of why man fails to achieve that of which he is capable; the late effects of any combination of these harmful influences on individuals have been its major preoccupation. This is the result of the evolutionary process of medical treatment of illness and the emphasis on understanding pathology preceding the development of principles of preventive medicine.

People become emotionally ill because they have exhausted their personal resources for dealing with the stresses they have encountered. Since so many of these stresses are invisible (being emotional conflicts within the individual), they do not seem reasonable to the untrained observer. The behavior of the distressed person frequently excites revulsion, hostility, embarrassment, or rejection—rather than sympathy, compassion, and a desire to help as with physical illness or injury. Furthermore, since all persons have varying degree of conflict, frustration, and repressed desires, exposure to an obviously troubled person may stimulate painful anxiety.

Although every individual responds in a unique manner to the particular constellation of troubles that have beset him, there are a few general patterns of reaction that occur with great frequency and are referred to by psychiatrists and their colleagues as neuroses, psychoses, character disorders, or psychosomatic symptoms (with a variety of subdivisions in each category). Overdependence upon these diagnostic categories may become an obstacle to clear thinking. Present-day sentiment in psychiatry is to place primary emphasis on an attempt to understand every factor that has been influential in reducing a patient's effectiveness rather than on giving a name to the disorder. This does not suggest that a diagnosis is any less important than it has ever been, but rather that the concept of what constitutes a diagnosis has been greatly enlarged.

Psychiatrists may aid in prevention by treating persons in the early stages of their disorders and mitigating the effects of psy-
THE NATURE OF PSYCHIATRY

V.

PSYCHIATRIC PRACTICE

Within the framework of a concept of universal human nature, psychiatry stresses individual (unique) responses and tries to avoid generalized solutions. This approach attracts as practitioners those who are more tolerant of differences and who in fact generally prize individuality above conformity; conversely, such individuals are the ones who elect to practice psychiatry in the first place. It seems obvious that the process is a circular one, and that any individual's choice of psychiatry as a profession is at least highly complex and probably overdetermined. It is also clear that, according to the prevailing view, psychiatrists are individualistic and isolationist.

Here we find an excellent example of a conflict of values. Most physicians use these terms pejoratively, perhaps even as an accusation. The description may be apt, but many psychiatrists view it positively and not as something against which to defend themselves; they see conformity as inimical to maintenance of personal opinions and feelings, discrimination, evaluation, and choice, loss of which leads to depersonalization.

There is, of course, the other side of the coin, that involving feelings of apartness and loneliness that lead to defensiveness. (Again, cause and effect are often inseparable.) These are the negative factors that cause (professionally) purposeless isolation, rejection of broad social responsibilities, and failure to establish communication with physicians. For example, some psychiatrists argue that doctors' complaints and criticisms stem primarily from their own unconscious conflicts. A case in point is that of the psychiatric administrator who insisted that other members of the
Faculty were simply "showing their unconscious hostility toward psychiatry" whenever they deplored his department's inadequate liaison services. It is similarly self-protective and defensive to deny inability to diagnose a referred patient or to refuse to acknowledge that, for whatever reason, treatment has failed. Another defensive maneuver is to put all the blame for therapeutic failure on uncooperative relatives.

Problems Contributing to Isolation

Psychiatrists occupy various positions on the "organic-dynamic" continuum and thus differ among themselves in their attitudes toward such procedures as electroshock and drug therapy. The charges by general physicians that they misuse or overuse such procedures indicate that psychiatrists are not incapable of overdoing a good thing or going too far in attempts to employ tangible treatment. Physicians also feel that some psychiatrists maintain a psychodynamic viewpoint to the exclusion of others, with consequent condescension toward and even denigration of other medical practitioners. Medical listeners sometimes believe that the psychiatrist lecturer tends to parade the mistakes of the general practitioner in a spirit of disrespect, hauteur, or frank condemnation. As one general practitioner has said, "The psychiatrist speaker spends the bulk of his allotted time recapitulating the errors of omission or commission made by generalists in the handling of patients with psychiatric disorders." The psychiatrist also deprecates his medical colleague who, implicitly or explicitly, asserts that collaboration with a nonpsychiatrist is a waste of time because the latter has neither the capability nor interest necessary to an understanding of psychodynamic principles. Other aspects of this problem are discussed below; suffice it to say that the speaker who addresses his audience this way is bound to elicit a negative and antagonistic response, and this is as true in a one-to-one confrontation as in a lecture hall.

In an article, Harvey Smith observed:

The 'outsider' status of psychiatry in medicine has given the field an air of defensiveness. It is and it behaves like a minority group, being sensitive to attack, constantly analyzing the sources of hostility, and preoccupied with 'selling' itself. Psychiatry is the butt of medical jokes, and its special language is a source of innocent merriment to other physicians. It has been described as a rejected sibling in the medical specialties which has developed habits of self-defense and constantly attempts to prove its legitimacy. . . .

All professions make use of technical terms and phrases peculiar to their own tasks. Such "languages" are a convenient shorthand to those who are familiar with their denotations and connotations and with the broad assumptions they represent. But jargon is not an effective way of communicating with outsiders; in fact, it can make communication impossible and cause the listener to wonder whether in fact the speaker is not trying to do just that. Under such circumstances the use of professional jargon can be ridiculous and even offensive; it is amusing until it is used in the service of obscurity, that is, defensively. Sharing ideas is, of course, very rewarding and brings people closer together; in common parlance we often use the phrase "He talks my language" to express admiration and affection (by implication arising from understanding). Psychiatric jargon is appropriate for psychiatrists; the content of psychiatric concepts can also be expressed (although not so quickly or easily) in everyday English. The use of "psychiatre" sometimes indicates to a physician that a psychiatrist wants to keep him "in the dark" or "at a distance"; at the same time the mysterious-sounding terminology may strengthen his belief in the omniscience of psychiatry and cause him to overvalue psychiatry in a detrimental comparison with his own treatment. In any case the result will be a negative attitude toward psychiatry on the part of the physician.

Conversely, psychiatric language is also used inappropriately by those outside the field. Norman Zinberg points out:

It is hardly necessary to document the extent to which psychoanalytic thought has pervaded every aspect of modern American life. . . . But the spread of ideas is by no means synonymous with accuracy and clarity. Acceptance of psychoanalysis in the language and thinking of our time has been matched by misuse and misconception. In every-
day use, psychoanalytic terms not only often have a pejorative connotation but are divorced from any kind of conceptual precision. In conversation, 'compulsive' usually means 'finicky' or 'repetitious'....

Sadly, even in the many professions which employ psychoanalytic theories in their own work, even these few concepts that have come to have specific meanings in the semantic jungle of psychoanalytic theory are used generally or in contexts so different from the original ones that the meaning is altered. What is worse is that many of the people in other fields using these ideas have had little opportunity for comprehensive training in psychoanalytic theory, which is always based on clinical evidence and experience. Instead, they have rooted around in the psychoanalytic literature, especially that of Sigmund Freud, and when they wish to 'apply' something, they quote isolated passages. These quotations are especially misleading because of Freud's and others' continuous reformulations, modifications, and revisions of their hypotheses in the light of accumulating clinical data. This is not to say that in psychoanalysis there has not been a relatively orderly development of ideas, but rather that the complex nature of these developments lends itself to diverse formulations and popular misconceptions.17

Isolation Need Not Be Alienation

Psychiatrists are not threatened by lack of professional cohesion, although other physicians are often disturbed by the schisms and factions existing within the specialty. This can be confusing, as when a "psychiatric opinion" is solicited and none is forthcoming. However, it would surely be unwise to ask psychiatrists to deny a diversity of professional judgment for the sake of convenience. Such action, although perhaps reassuring to those demanding pat answers, would represent gross intellectual dishonesty.

One practical aspect of "isolationism" is illustrated by the failure of many psychiatrists to involve themselves in the affairs of organized medicine through attendance at medical society meetings, staff meetings of general hospitals, and so forth. Certainly all physicians bear a responsibility for participation in professional activities. Whether psychiatrists are the most delinquent of a group seen by the public as being made up of rugged individualists is a
VI.

THE MIND-BODY DICHOTOMY

The emphasis on the physician-patient relationship reflects a general belief that such rapport is not merely a pleasant therapeutically insignificant mutual affection but rather that it is closely connected with efficacy of treatment, that is, that the mind and body are not separate, discrete entities whose functions are unrelated.

Nonetheless, despite recognition of the fallaciousness of the mind-body dichotomy, the concept remains entrenched as an influence of many of our attitudes; despite an awareness of its inapplicability, we seem to find it difficult to refuse to accept this legacy from the Judæo-Christian tradition.

In this area disparities between unconscious attitudes and those arrived at through reasoning and intellection are by no means limited to the uninformed. Karl Menninger has noted a "secret arrogance" on the part of some psychiatrists that arises from a conviction that concerns of the mind and spirit transcend those of the flesh and thus that the professional preoccupations of psychiatrists are on a higher level than those of medical colleagues.26 (And it is likely that some physicians in other specialties harbor feelings of inferiority for the same reason.) This attitude of superiority may be displayed openly, as it was by the psychiatrist who insisted that the judgment of a certain psychoanalyst could not be trusted because that analyst was "really only a neurologist." Similar disparaging attitudes toward the nonpsychiatrist and toward physiological medicine may appear in such other guises as a belief that psychiatry has all the answers, condescension toward a physician requesting psychiatric consultation, failure to communicate with the referring family physician, and disinclination to participate in hospital staff or medical society. The unwary psychiatrist may actually obstruct the integration of the psychological and physiological aspects of medicine.

Since psychiatrists have from the beginning been leading exponents of treatment of the "whole" or "total" person, nonpsychiatrists may discover with some surprise that some psychiatric colleagues appear to minimize the physical aspects of health and disease. By refusing either to carry out physical and neurological examinations themselves or to arrange for them, by emphasizing emotional factors in illness to the point of neglecting organic diagnostic work, by delaying medical procedures, and by failing to keep up his fund of essential medical knowledge, the psychiatrist affects a "do as I say, not as I do" attitude. In the Presidential address he delivered at the May 1961 Meeting of the American Psychiatric Association, Robert Felix reaffirmed that the psychiatrist is, above all else, a doctor of medicine, and insisted that psychiatrists must retain their basic competence as physicians. After asserting that a psychiatrist can be expected to carry out a dependable general physical examination, and after calling attention to the types of emergency medical conditions to which any psychiatrist must be ready to respond, Felix deplored the tendency of many young psychiatrists to neglect their general medical knowledge and skills. Felix epitomized his point of view by asking his audience whether that psychiatrist is qualified to engage in practice who cannot demonstrate skill in the diagnosis and treatment of medical conditions that is equal to the psychiatric skill he expects of nonpsychiatrist colleagues. Obviously, whenever psychiatric physicians diminish the importance of the physical aspects of illness and health they invite criticism.

By exaggerating the importance of emotional factors in illness, the psychiatrist becomes one of those who look at the part rather than at the whole; he widens the gap between psychological and physiological medicine.

The psychiatrist who ignores the physical aspects of disease and
places unwarranted emphasis on psychological factors in health and illness, himself recreates the very mind-body dichotomy that we struggle to abolish. One psychiatrist said that “it is incorrect to speak of mental health or mental illness for by speaking of mental health, we perpetuate the notions of separateness of mind and body and of difference between mental function and physical function.”

VII.

THE MANPOWER SHORTAGE

Regardless of the approach or direction taken, any discussion of the difficulties of current medical practice (including psychiatry) must concern itself with a fundamental issue: the manpower shortage. There are several contributing factors, all of which are interrelated.

The statistics on the incidence of mental illness are, by now, dishearteningly familiar. Approximately one-half of all hospital beds in the United States are occupied by mentally ill patients. Seven hundred thousand such patients are hospitalized at any given moment, and over 1,000,000 patients are treated annually in mental hospitals in the United States (in addition to the substantial number of persons treated in clinics and by private psychiatrists).

It is well known that qualified psychiatrists are in short supply and currently comprise about 7 per cent of the registered physicians in the United States. This shortage exists despite a ninefold increase in psychiatric residency training facilities over the three decades from 1930 to 1960. In 1930, 89 training centers offered 410 residencies; by 1960 these centers had increased to 303, and the number of available residencies rose to 3,658. Of interest here is information supplied by the Menninger Foundation School of Psychiatry, by far the largest psychiatric training center in the United States. In its 1962 brochure, the School reports that 735 physicians had entered its three-year program since its inception in 1946. The 16-year output of that center should be evaluated against the backdrop of needs projected by the Joint Commission on Mental Illness and Health. Even more dramatic evidences of shortage were disclosed by a nationwide spot check of 50 county
medical societies conducted by the APA General Practitioner Educational Project during the summer of 1957. In their responses to the questionnaires circulated, 59 per cent of the societies reported there were no psychiatrists available in their localities, 10 per cent reported a grossly inadequate number of psychiatrists, and another 23 per cent reported a mild shortage of psychiatrists. A total of 85 per cent of the responding societies, then, reported a shortage of psychiatric manpower in their communities despite the fact that, from 1946 to 1960, the number of psychiatrists active in the United States increased by 300 per cent, and the total membership of the American Psychiatric Association reached an all-time high of 11,637 in the year 1960-1961. During the six-year period beginning in 1950, there was a 57 per cent increase in the number of psychiatrists. These statistics can be compared with the projected needs for psychiatric manpower.

The compelling necessities with which they must deal become a matter of deep concern to many psychiatrists who realize that, in a lifetime of professional activity, each psychiatrist helps relatively few people.

The exact number of noninstitutionalized persons who suffer from psychological illness is unknown. However, certain rough indications can be derived from the incidence of unsocial behavior that is almost invariably associated with mental or emotional disturbances. It has been estimated that 1,750,000 serious crimes are committed yearly in the United States, that 50,000 persons are addicted to the use of drugs, and that there are 3,800,000 problem drinkers. In addition, practicing physicians estimate that from 30 per cent to 60 per cent of their patients suffer from some form of psychological disturbance. A study done in the Department of Internal Medicine of the State University of Iowa College of Medicine revealed that psychophysiological disturbances were responsible, wholly or in part, for the illnesses of 47 per cent of 2,038 unselected medical patients. A similar study disclosed that 31.4 per cent of 1,000 unselected outpatients with puzzling diagnostic features — after all organic factors were eliminated — had a psychological basis for their complaints and illnesses.

VIII.

ENLARGING RESPONSIBILITIES OF PSYCHIATRY

As the preceding figures reveal, the definition of psychiatric illness has broadened to include social illness. This means that psychiatric treatment is seen as the appropriate method of dealing with such problems as delinquency, addictions, acts of aggression and destruction, and so forth. Not only is the total population increasing far more rapidly than the number of psychiatrists, but additional categories of illness are considered suitable for their care.

The public's growing sophistication about the nature of mental illness and psychiatry is responsible for this shift, as it is for the tendency toward earlier recognition of symptoms of emotional disturbance. Psychiatry is seen less and less as a last resort. There is increasing reluctance to dismiss the mentally ill as lost causes and increasing insistence on their rehabilitation as healthy and productive members of society.

Traditions of psychiatric practice (especially psychotherapy) such as the 50-minute hour and fairly rigid daily schedules limit the number of patients a psychiatrist can treat. Maintenance of detailed records, a requisite of treatment, is extremely time-consuming. The inadvisability of interrupting the course of psychotherapy or psychoanalysis restricts the psychiatrist's geographic mobility, and the one-to-one relationship (and ratio) that usually obtains is also significant in determining the relatively low number of patients he sees.

Another factor that prevents many of those who need it from getting psychiatric care is its high cost. The average cost of individual and private psychotherapy or psychoanalysis is $20.00
There are mental health centers and clinics whose fees are proportionate to patients’ incomes; there are mental health facilities and individual psychiatrists who offer group therapy, which is less expensive. Nonetheless, in general its cost represents a real obstacle to psychiatric treatment.

Furthermore, mental patients are subject to a form of financial discrimination. With few exceptions both individual and group accident and health insurance policies provide less coverage for mental or emotional illness than for organic illness. The policies usually provide for lower rates of payment and shorter periods of hospitalization; their terms are more appropriate to surgical treatment. Such discrimination against psychiatric illness encourages both physicians and patients to conceal psychological disturbance in the hope of avoiding the substantial expense of treatment. Families without insurance coverage may be unable to pay for psychiatric therapy, and those with it are likely to find it inadequate.

That provision of psychiatric service falls so far short of recognized needs indicates the necessity for examining certain of our current “solutions”; the clear indication is that, as responses to problems of medical and psychiatric care, they are inadequate. And the inadequacies may well be qualitative as well as quantitative.

There simply are not enough psychiatrists to deal with all the mental health “problems” in the United States. This is one reason for the advisability of delegating responsibility in this field to those in allied professions. The greatest single resource now not being fully utilized in the care of those with emotional conflict is the general physician.

In many cases the physician is the first professional point of contact for a person with a mental or emotional disturbance. He may not necessarily be approached because of the difficulty; in fact, the patient may be unaware of the nature of his problem. However, he (or his family) may be aware that some kind of treatment is needed. As pointed out earlier, this kind of encounter at least indicates a need for support, and in many cases will prove to be, more strictly speaking, a “psychiatric” problem. Moreover, patients who are aware that their problems are psychiatric often go to their physician first.

The current trend in psychiatric care is away from hospitalization toward treatment in the patient’s home community and, if possible, while he continues to maintain his job and his relations with family and others. Lack of disruption of routine and the continuing presence of people with whom the patient is familiar provide reassurance and support, and are now considered to be therapeutic practices. Earlier diagnosis makes this possible; that is, treatment can be started before symptoms have become fixed or extreme. Similarly, less drastic forms of treatment are effective. As mentioned earlier, certain psychotherapeutic skills are appropriate to general physicians, and patients are disturbed by their ab-
sence. But by delegation of responsibility is meant more than encouraging physicians to be sympathetic, and it is at precisely this point that difficulties and opposition arise.

The Controversial Role of the Practitioner

There is conflicting evidence about the nonpsychiatrist's desire to add to his understanding of the psychiatric aspects of his patients' illnesses. On the one hand, the Chairman of the Ad Hoc Committee on Mental Health of the American Academy of General Practice wrote in February 1957, "We know that our only hope for an emotionally healthy nation is a psychiatrically alert group of family physicians." Increasing interest in additional psychiatric training and experience was expressed by a large proportion of the 405 doctors who responded to a Gallup Poll in New Jersey in 1954. This survey disclosed "findings ... which suggest that there may be an extensive latent interest in the specialty, e.g.: over two-thirds say they like to have an informative pamphlet on this subject; 41 per cent say they would definitely attend a seminar in psychiatry if one were offered in their community and another 14 per cent say they might." In addition, postgraduate courses in psychiatry given for the general practitioner at numerous university medical centers and by psychiatric societies and private psychiatric institutions have been reasonably well supported and attended. In his 1962 report, the Chief of the APA General Practitioner Education Project called attention to the "spontaneous demand by practicing physicians for further (psychiatric) education" and noted that from 60 to 75 per cent of the postgraduate courses in psychiatry presently being offered were initiated during the past three years; the number of postgraduate courses in psychiatry is now greater than those devoted to any other specialty.

On the other hand, many general physicians avoid approaching their patients psychiatrically and have serious reservations about using psychiatric principles in their daily practice. To these physicians, as Hyman points out, mental disease suggests a chronic illness with a prolonged therapeutic period, limited chance of cure, and consequent frustration and disappointment on the physician's part. Some general physicians, finding psychiatric techniques and approaches confusing, prefer a more direct "organic" approach, which they presume will produce more immediate therapeutic results. The possibility that general physicians may not be eagerly interested in absorbing the insights and knowledge of dynamic psychiatry was disclosed in a 1956 study conducted by Peterson et al in North Carolina. The research team found that only 17 per cent of the general physicians surveyed recognized emotional problems in their patients and treated them in a manner demonstrating a sufficient grasp of appropriate treatment methods. Another 54 per cent did identify emotional problems but made no effort to institute psychological treatment; they directed their therapeutic efforts only to the physical aspects of the patients' problems. In commenting on their findings, the investigators note the physicians who "while recognizing the (emotional) problems, were either indifferent to them or appeared to be made uncomfortable by patients with such problems."

These findings are consistent with physicians' basic orientations. Taylor suggests that "psychiatric skills may even be maladaptive for the general practitioner." But it would be a mistake to think of all resistance by physicians to psychiatric approaches as "stubbornness." There are physicians who (as was pointed out by a psychiatric resident who began his training in psychiatry after eight years of practice in general medicine) persist in the belief that to explore psychological factors is to trespass on forbidden territory. This attitude may be encountered by the liaison psychiatrist who urges his medical colleagues to involve the patient in a psychotherapeutic regime himself. Such a suggestion not infrequently causes surprise and consternation. The nonpsychiatrist replies: "I'm no psychiatrist. I wouldn't know what to do when his psyche began to get out of control. I would be afraid to probe for fear of what might happen."
Some physicians who are disinclined to learn psychotherapeutic techniques believe that psychotherapists are born and not made, or see little difference between the trained medical psychotherapist and any other counselor, advisor, or sympathetic listener. Others, caught in the mind-body dichotomy, do not want to become involved with things psychiatric.

Such physicians are not helped by psychiatrists who maintain a “do-it-myself” attitude. The nonpsychiatrist feels frustrated when, after psychiatrists have repeatedly stressed the importance of the psychological approach to all patients, he is denied admission to scientific meetings of psychiatric societies. An officer of a Midwestern society who refused to permit a psychologically oriented general practitioner to attend an evening lecture on a topic of broad interest justified his action by saying, “We don’t want general practitioners doing psychiatry!” Such an attitude discourages physicians interested in developing psychotherapeutic skill and limits the number of physicians doing psychotherapy.

The fundamental issue is: to what extent should a physician use psychiatric principles and techniques? At what point does he begin “doing psychiatry” in a dangerous way? Obviously there are no easy answers, and answers of any kind will be difficult to arrive at using this approach. Put differently, there are certain instances in which a psychiatric orientation will benefit physician, patients, psychiatrists, the community, and (ultimately) the whole population.

Noncontroversial Principles of Practice

As we have seen, the old adage about an ounce of prevention applies to mental and emotional problems. Savings of time, energy, and expense can be effected if signs of trouble are picked up early, and physicians are in a good position to do so. But a psychiatric orientation is necessary for detection, and some psychiatric skills for diagnosis and treatment. (Intensive or long-term treatment is not necessary for many such cases, which come under the category of “prevention.”)

At the very least, consideration of a patient’s mental and emo-
tional status should be included in a physician’s medical evaluation procedures.

Furthermore, general physicians should recognize the significance of “normal crises” in human lives, such as the menarche, puberty, marriage, menopause, and retirement. Any physician or student exploring the feelings of bed patients can observe the effect of hospitalization on psychological function. Both psychiatric and nonpsychiatric physicians express dissatisfaction with psychological preparation of some patients for surgery; they find themselves confronted by emotional complications secondary to surgery in both children and adults.

Many medical practitioners should be aware of the effects of such common occurrences as separation of the mother from members of her family, should know the meaning of loss of health to human beings, and should recognize the necessity of completing the process of mourning when a loved object (whether health, youth, or a close relative) has been lost. The family doctor should be aware of the extent to which psychophysiological disorders, as well as the more patent psychiatric disturbances, are rooted in the family constellation, and of the effects of alterations in the intensity of basic needs and impulses, such as dependency and aggression, either upon the individual or upon the interrelationships of the family unit.

A physician should, of course, be able to recognize psychoses, and it would be valuable if he could recognize, for example, somatic equivalents of depression. Such cases are extremely provoking to the physician who is unaware of their true nature. They can involve him in long, complicated, and fruitless courses of treatment. A physician who recognizes such cases can save tremendous expenditures of useless time, emotion, and energy; he can avoid giving inevitably futile care.

Resistance to Psychiatric Help Is to Be Respected

Finally, of course, not all resistance to psychiatric concerns originates with physicians, but with patients, and the physician is then in the position of having to overcome it—a procedure with which
he is unfamiliar and therefore may be reluctant to undertake. In such instances he is forced into a kind of isolation—that is, he is viewed with hostility by the patient. As we have seen, general physicians are less tolerant of this than are psychiatrists.

The individual is prone to regard with fear and loathing any specter of psychological illness within himself and to shun any possibility that he might suffer from a disease of the mind. The general physician is, therefore, often challenged to overcome the opposition of a patient who needs help with psychological problems but who rejects the thought that he may have mental illness. The physician's task may be further complicated if, by identifying psychological components of the patient's illness, he activates deep-seated, irrational fears of death, punishment, ostracism, or "incarceration in an asylum." The patient with emotional difficulties may regard his doctor's inability, unwillingness, or failure to assign a physical origin to his symptoms as evidence of lack of interest or affection. The patient may therefore desperately resist the physician's efforts to refer him to a psychiatrist. The prepsychotic patient who utilizes psychophysiological symptoms to protect himself against a psychosis may cling even more desperately to those symptoms. All of this can make the general physician extremely uncomfortable.

Collaborative resistance rooted in the psychodynamics of family life may not yield to the physician. Some families seem to need to keep a member helpless, immature, or infirm. Such a family conspires silently to assign the role of patient to the most susceptible member. It sends that member as an envoy to the physician, who may find it hard to decide whether the messenger is actually calling for help or warning sublimly against upsetting the precarious family equilibrium. It is essential that the family physician read the message correctly. For example, a child whose family considered him to be a slow learner was evaluated medically, first at the insistence of his teachers and then at the request of his parents. When no physical disease or organic impairment of intellectual functioning was found, the family would not permit psychiatric and psychological evaluation of the child until school authorities demanded

it. When those studies, which demonstrated that the youngster was actually bright, were reported to the parents, deep rumblings could be heard from the very heart of the family constellation. The mother soon became alcoholic and irresponsible, and the father began to speak of divorce.

Physicians who avail themselves of opportunities for learning the basic principles of psychiatry (and whose efforts in this direction are not thwarted by monopolistic psychiatrists) can serve themselves and their patients better. They can take an active part in prevention, provide appropriate treatment, and make efficient arrangements for care by psychiatrists when necessary. These points will receive further consideration in the next section.
REFERRAL AND CONSULTATION

The phenomena of psychiatric referral and consultation often constitute "psychodramas" in which the misunderstandings and conflicts between general physicians and psychiatrists are played out. In such situations are exhibited all the disparities in orientation and values, the failures in communication, the laboring at cross-purposes of which we have been speaking; no doubt they occur most often in this area because it represents the most frequent and immediate encounters between the two groups. Of course, as with undertakings of other kinds, the instances in which things work out to everyone's satisfaction receive less attention than those that provoke dissatisfaction, but at least the latter are potentially educational.

Psychiatric Practice Requires
A Different Approach to Patients

Medical colleagues complain that psychiatrists are not always available when needed. They say that certain psychiatrists are reluctant to make house calls, to see a patient in consultation in another physician's office, or to see a patient in consultation at the time when the acute problem exists. One physician reported that he "gets the brush-off from the psychiatrist who tells me that he would be happy to see the patient by appointment in his office three weeks from next Tuesday." The private practitioner often feels annoyed with the psychiatrist who makes such a proposal because he has a problem that he must solve at once.

A physician may be impatient with his psychiatric colleague when he calls him on the telephone and is told that he is with a patient and cannot receive the call. He may not be fully aware of the fact that psychiatric interviews are often of such a delicate nature that an interruption may interfere seriously with a whole hour's work. The suggestion that an appointment be made "on the hour" may strike the caller as a species of discourtesy.

The manner of organizing one's daily schedule is also a subject of frequent misunderstanding. A psychiatrist in private practice usually has a series of office interviews, each lasting nearly an hour, extending through the day. This means that if an emergency situation arises, the psychiatrist is faced with the necessity of failing to accept responsibility for a new patient or cancelling an appointment that is possibly of long standing. In either case, he is likely to give offense. Those psychiatrists who practice in groups can solve this problem by having one of their members be on call at regular intervals, thus enabling emergency situations to be met in more or less the same manner as other specialists care for emergencies.

Psychiatrists with a "general practice" in psychiatry are relatively uncommon, especially in urban centers. If general hospitals organize their services so as to care for psychiatric emergencies in the same general way they look after surgical and medical acute illnesses, the pressure is likely to be reduced on the private psychiatrist in the community. Any physician may get a consultation, and definitive psychotherapy, if indicated, can be arranged for when convenient.

Physicians claim psychiatrists are too busy to accept referred patients. This is not always readily understood by the referring physician. There are two facets to this subject. One has to do with the time-consuming nature of psychiatric examination and therapy, particularly if the therapy is psychoanalytic. The other is the lack of information on the part of referring physicians as to what kind of patients should be referred to the psychiatrist. Some physicians will refer only the completely worn-out cases of patients who have been already subjected to a great number of examinations, tests, and treatments, including surgical treatments. Other physicians (from experience, relatively few) will refer a patient to a psychia-
trist when the treatment might well be conducted by the referring physician himself, were he willing to give the time necessary to inform himself of the possibilities of such treatment and to apply it. On the other hand, many physicians, particularly those who obtained their medical education before psychiatry had much of a place in the medical school curriculum, are still inclined to believe that only definitely psychotic patients should be referred to psychiatrists; or, the physicians prefer to refer other patients, if they do so, with the explanation to the patient that he is to see a neurologist and not a psychiatrist. The matter of choice of patients for referral is being managed better and better as time goes on. Getting psychiatrists to modify their views about assigning appointments to all patients on a standard time and frequency pattern is a somewhat more complicated matter. Certain standards of procedure are required or at least have become generally accepted by some psychoanalysts. The availability of psychiatric treatment service is considerably limited by rigid adherence to them, e.g., frequency of visits, the 50-minute hour, and the considerable expense involved. It is difficult to get other physicians to accept these procedures as being reasonable.

Psychiatrists might well devote some effort to finding ways of handling more referrals, requests for consultation, and psychiatric emergencies. The Director of Outpatient Clinics of the New York State Department of Mental Hygiene commented, The high incidence of relapse among patients shortly after leaving the hospital often results in unnecessary rehospitalization. Since these relapses are particularly apt to recur on weekends, holidays, and at night, this points up the importance of having assistance immediately available to patients and relatives in a psychiatric setting as well as in general medical practice.

Expectations of Psychiatrists Are Often Unrealistic

General physicians often reveal their unrealistic expectations of psychiatry, as well as their hostility to it (which may result from the former), in attempts to arrange for referral or consultation. For a variety of reasons, some nonpsychiatrists believe that psychiatrists can produce near miracles. Patients referred by these general physicians often are poorly prepared and promised too much. A Minnesota psychiatrist reports being asked to see a young matron with a chronic psychophysiological disturbance who had been told by her family doctor that "you [the psychiatrist] could clear up my difficulties in two visits." A later conversation with the referring doctor confirmed the patient's report. The referring physician with boundless enthusiasm for psychiatry tends to become disillusioned, disappointed, or even antagonistic toward psychiatry as his expectations go unrealized. He may, for example, complain that a particular psychiatrist "didn't do anything" or "sat in silence for hours on end." He may also complain that a psychiatrist "in desperation" resorted to a different form of treatment "because he didn't know what else to do" or that a given patient, dissatisfied with psychiatric treatment, had sought help elsewhere. Implicit in such remarks is dismay resulting from the realization that a particular psychiatrist, and therefore psychiatry, has limitations and that psychiatric techniques do not always solve the clinical problems. Of course, some psychiatrists do sit in silence (appropriate and otherwise), do become frustrated or even desperate, and do fail to help people in distress.

Nonpsychiatrists reveal their overexpectations when, as members of a medical society program committee, they ask the psychiatrist to speak on metapsychological, philosophical, legal, or religious topics. Similarly, nonpsychiatric members of a medical school committee on admissions may leave the assessment of an applicant's "motivation" entirely to the psychiatrist, and expect him to evaluate the suitability of the applicant for the study of medicine and even to make "predictions." In interdepartmental conferences or panel discussions, the nonpsychiatrist participant may sidestep a particularly thorny or abstruse question that has arisen and say, "I am sure that my psychiatric friend will want to answer this one when it comes his turn to speak. I will therefore defer to him." In these and other ways the general physician demonstrates his failure to recognize that the psychiatrist can no more work wonders than can he.
Physicians who are hostile to psychiatry can do a great deal of harm. When such a physician is on a medical school faculty he may influence the attitudes of students toward the emotional aspects of their patients' illnesses and disenchant the student with psychological medicine. A patient referred by a physician who is antagonistic toward psychiatry may be either unprepared or poorly prepared for his appointment with a psychiatrist, and may present a difficult diagnostic or therapeutic problem to the psychiatrist. His resistance to psychological appraisal and introspection may be reinforced because he has observed that "Doctor Jones doesn't believe in psychiatry." Furthermore, physicians may actually use psychiatric referral as punishment for the patient's failure to respond to treatment.

Many patients are inadequately prepared for psychiatric consultation and treatment. Some get the impression that psychiatric care is prohibitively expensive, time-consuming, or nerve-wracking. By failing to correct such misconceptions the physician bolsters the natural reluctance of human beings to explore their inner selves and perpetuates resistance to needed psychiatric treatment.

One poorly prepared patient asked her psychiatrist, "When did you have your mental breakdown?" The psychiatrist found later that the referring physician, trying to persuade the patient to accept a course of psychotherapy, had commented that her symptoms were not unlike those he himself had once experienced. He had continued by reporting that, during a cocktail party chat, the psychiatrist had disclosed that he too had had a similar problem. The psychiatrist then recalled that he had commented, "I know how you must have felt," upon hearing of his colleague's problem, and realized that his friend must have concluded that the psychiatrist had once had the same difficulties. The patient refused a second appointment.

There are several reasons for inappropriate referrals. Many referrals are made because physicians are anxious about patients with emotional difficulties and wish to be rid of them. (The outstanding characteristic of such cases is that patients are insufficiently prepared.) A survey of a group of generalists who made 23 referrals to a single psychiatrist during a two-year period revealed that in at least 25 per cent of these referrals the referring physician was motivated primarily by anxiety produced by his own unrecognized or unwelcome feelings toward the patient, and not by reality of the medical problem. In later group discussions, the involved physicians could identify the emotional state behind the referral—acting anxiety. Physicians had become anxious because they either disliked the patient or felt uncomfortably solicitous toward him, were afraid of the patient, or felt vaguely threatened by a variety of feelings that had been mobilized by the verbal and nonverbal communications of the patient. Obviously, this significant aspect of the physician-patient relationship can influence the physician's psychiatric referral policies.

"Premature" referrals are sometimes made by the physician who wants his patient to receive the benefit of all that medicine has available. They can also result from the physician's lack of scientific sophistication and from his unfamiliarity with the indications for psychiatric consultation. The doctor who originally assumed responsibility for the care and treatment of the patient sometimes advises psychiatric consultation merely because all his earlier diagnostic and therapeutic efforts have failed; in his frustration he turns to his psychiatric consultant. (If, after making the referral, he shows little further interest in the patient, he can be charged with "dumping" the patient on psychiatry.)

On the other hand, a referral can be ill-timed because conditions have been allowed to develop that make a therapeutic relationship impossible. For example, a patient who has developed a transference neurosis with his former physician relates to his doctor as if he were a parent. Such transference neurosis enormously complicates the task of the consulting psychiatrist. Such a patient may tell the psychiatrist that he loves or hates his physician. When the psychiatrist seeks to involve the patient in psychiatric therapy, the patient makes it clear that he wishes only to resume his relationship with his doctor.

The other side of the coin is represented by physicians who completely refrain from making psychiatric referrals. Many physicians
still believe that they can make a psychiatric diagnosis only by exclusion; consequently, they conduct a “needle in the haystack” search for possible organic abnormalities. Unfamiliar with the criteria of emotional or mental disease, these physicians endlessly perform physical examinations and conduct laboratory studies, which are often demanded by the frightened and concerned patient who pays for them. In this manner, the general physician may unwittingly fix the organic-appearing symptoms.

A referral can also be sabotaged if the nonpsychiatrist fails to specify the precise nature of the problem and the kind of help he expects of the psychiatrist. Referring nonpsychiatrist physicians often request merely “EOA” (Evaluation, Observation, and Advice) in hospitals and clinics or send a patient to a psychiatrist in private practice without furnishing medical data. Apparently they don’t see the necessity of providing all pertinent available information, although the medical findings are essential to a thorough-going psychiatric evaluation. Many physicians try to justify themselves by explaining that they thought “the patient would tell you the whole story.” These same physicians, however, would not refer a patient to a cardiologist without a complete summary of his historical, physical, electrocardiographic, X-ray, and other laboratory findings.

A False Formulation: Soma or Psyche, Psychiatrist or Nonpsychiatrist

Perhaps the real issue in such circumstances is that physicians fail to see a connection between medicine and psychiatry, and therefore between physical and psychiatric illness. Their basic assumption is that mental or emotional illness, even if it produces physical symptoms, is not “real.” Unfortunately it is not unheard of for a physician, upon completion of a physical evaluation, to remark, “There is nothing the matter with you; you ought to see a psychiatrist.” At this point the damage has been done, because the physician has implied that: (a) he wants to get rid of the patient; (b) the illness is imaginary; (c) the psychiatrist is undertaking a futile task (and the patient may well wonder what manner

of man would do that). The patient will feel unlike, rejected, and unworthy of interest or effort; the psychiatrist will have to deal with such feelings and, in addition, contradict the referring physician by showing that troublesome and even incapacitating illness can exist without physical pathology. It is not without reason that psychiatrists often regard their diagnostic and therapeutic efforts as being scuttled before they ever saw the referred patient.

Another typical remark that betrays a general physician’s lack of respect for both the referred patient and the psychiatrist is made after referral: “Well, I guess I was wrong. Dr. Smith thinks you are crazy after all.”

This kind of reaction is far worse than refusal to discuss the consultant’s findings (even in general terms), but the latter can be frightening to a patient because it implies that the situation is unspeakable. Actually, the physician may simply be using extreme methods of avoiding indiscretion.

The question of what or how much to say is a difficult one, and psychiatrists often invoke the need to maintain confidentiality and protect privileged communication in an attempt to answer it. Physicians often feel that psychiatrists withhold information needlessly. Psychiatrists should be able to provide certain facts about diagnosis, prognosis, and progress without disclosing “lurid details”; similarly, physicians should be satisfied by professionally relevant information. Here again problems of communication are involved that can be partially solved by directness, for example, specific questions and answers, even if the psychiatrist’s answer sometimes must be, “I am sorry, I can’t tell you that.” Doctors have described situations in which the psychiatric consultant neither gave a definite answer to the questions nor admitted that he could not provide the requested assistance. Instead, the psychiatrist offered a long-winded discussion of the patient’s psychodynamics as a substitute for the requested medical opinion. Nonpsychiatrists complain in this connection, of the psychiatrist’s ambiguity when discussing the need for psychiatric treatment; they are confused by the psychiatrist’s inability to specify the form and goals of psychotherapy. Not infrequently the psychiatrist gives the referring physician too little
opportunity to relay important information concerning referred patients. This is important, for the referring general physician may know the patient and his family very well; he may even have assisted at the patient's birth. Whenever he does not listen attentively to the referring doctor's entire story, the psychiatrist opens himself to the same criticism that he levels at his colleague who does not listen carefully to what the patient is trying to say.

Psychiatrists Need to Remain Responsive To Their Medical Colleagues

Just as some physicians are intolerant of the psychiatric approach, some psychotherapists recognize only intensive and uncovering psychotherapy; they deprecate "superficial" therapy. The physician who has referred a patient with an obviously uncomplicated problem finds it difficult to understand why such psychiatrists hesitate to accept his patient. Hawkins points out that physicians expect psychiatrists to apply their clinical knowledge broadly and, when necessary, to shift freely from the typical analytical-psychological therapeutic set to a directive-organic approach. Psychiatrists should be able to deal resourcefully with a variety of psychiatric problems. Indeed, the whole key to relations between psychiatrists and physicians is flexibility. This does not mean compromising, but thinking (and therefore talking and acting) in other than traditional ways; a prerequisite is the ability to empathize with those whose orientations are different. For example, psychiatrists should always acknowledge a referral, enable the family doctor to maintain contact with the patient during treatment, check with the referring doctor before referring his patient to a specialist for treatment of organic illness (which may have existed at the time of referral or developed during the course of psychotherapy), and inform the family doctor of termination of therapy.

Members of the Massachusetts Medical Society have openly complained that a number of psychiatrists charge their fellow physicians fees for consultations and treatment and that it is not unknown for psychiatrists to charge medical colleagues a fee for a single consultation. Other physicians understandably take a dim view of the conduct of those psychiatrists who require their patients to pay in advance for professional services, such as a course of electroshock therapy of unspecified length. Complaints have been made that some psychiatrists charge excessive or even exorbitant fees, and there are those physicians who do not have to be prodded into reporting specific instances in which a patient has been overcharged for psychiatric services.

It is a time-honored principle of medical ethics that a physician should not charge another physician or a member of his family for medical service. This is consistent with the practice of psychiatrists insofar as diagnostic and emergency services are concerned; but when definitive psychotherapy is indicated, a very great amount of time may be needed that, if not paid for, results in a great financial sacrifice on the part of the psychiatrist. In some instances so much of their practice was taken up with persons whom it was unethical to charge that psychiatrists have been forced to leave a community. Particularly in urban centers this has resulted in the custom of making customary charges to physicians and members of their families for definitive psychotherapy. This has brought about much ill will and is a source of great misunderstanding.
XI.

EDUCATION AND TRAINING

Some of the factors contributing to the separation of psychiatry from medicine result from the respective natures of the two fields; others are not inevitable but result from and are perpetuated by education and training. Prior to 1950 the clinical years offered little more psychiatry to the medical student than did the preclinical. A poll of physicians conducted in New Jersey in 1954 showed that the majority of doctors did not stress developmental factors in their etiologic theses, that they are ahistorical in their approach, and that the (then) recent medical school graduates reported more emotional disturbances and psychosomatic diseases, and showed more concern with and sophistication about mental health problems, than did their older colleagues.

Psychiatry Is Now Inseparable from Medicine

In the GAP report entitled THE PRECLINICAL TEACHING OF PSYCHIATRY, the Committee on Medical Education compared the results of a survey of 81 American and 12 Canadian schools of medicine, conducted in the academic year 1959-1960, with related findings reported in 1942 by Ebaugh and Rymer. In 1940, 38 per cent of the nation's medical schools taught psychiatric courses during the preclinical years; by 1960 that percentage had risen to 90 per cent. The average number of preclinical curriculum hours assigned to departments of psychiatry rose from 20 in 1940 to 78 in 1950. The lecture teaching method is used during the first two years in 90 per cent of the courses. However, small group teaching is now a part of 60 preclinical courses taught in the 93 medical colleges surveyed. The GAP publication also reported a trend in the 1950's toward making use of the social and behavioral sciences in psychiatric education. (Support from the National Institute of Mental Health helps expand the teaching of the relationship of human behavior to health and illness.)

The American Medical Association's Council on Medical Education and Hospitals has stated:

There is a distinction between psychiatry in its relationship to medicine in general and psychiatry as a clinical specialty. The former is an indispensable part of all medicine; the latter is the province of graduate training beyond the internship. Aspects of psychiatry relating to the psychology of acute and chronic illness, of disability, of surgical intervention, of convalescence, and of the doctor-patient relationship are of common concern to all those who care for the sick.

Medical Practice Means Meeting

Patient and Community Needs

Psychiatry has become increasingly active in the continuing education of the practicing physician. However, this movement has not yet developed a cohesive education methodology. Not uncommon are "one-night" teaching stands for nearby general practitioners, consisting of a series of two or three talks given by members of the department of psychiatry or of the psychiatric society. At the opposite extreme are well-organized postgraduate psychiatric courses in which the supervised nonpsychiatrist participant is actively involved overtime in the evaluation and treatment of patients with mental health problems. Falling between these two pedagogic extremes are widely varied teaching approaches and combinations thereof that include lecture series, seminars, clinical conferences, clinical demonstrations ("live" or involving the use of closed circuit television and moving picture films), ward rounds, discussion of interview material obtained by the general practitioner, and so forth. Practical considerations such as available time, distance, financial support, and demonstrated interest largely determine the choice of teaching technique.

After years of hard work and financial sacrifice, young doctors
are eager to reap material rewards, and they see private practice as the best way of doing it. Moreover, medical school, internships, and residencies seem to foster the idea that private practice is the ultimate good—perhaps partly because physicians find independence so attractive. But if the physician shortage as well as other broad social problems is to be dealt with, some attempt should be made to encourage psychiatrists to do social and institutional psychiatry.

Education procedures can reduce some of the disparities in the orientation and values of physicians and psychiatrists if they are initiated early enough. They can encourage in medical practitioners in all fields a greater sympathy for and tolerance of such differences as must, because of the nature of the issues and practices involved, continue to exist.

Recognizing the value of both short-term and full training in psychological medicine for physicians, the United States Congress in 1957 gave the National Institute of Mental Health the responsibility and the funds to develop training programs. Practicing physicians who want full psychiatric residencies were offered stipend levels higher than regular training stipends. Many orientation and short seminar courses offer learning opportunities to practicing physicians who wish them.

The medical profession needs to respond continually to the challenge of new demands from the public and from within our profession if we are to achieve the high level of medical care that we desire for our patients. The Committee on Public Education of the Group for the Advancement of Psychiatry has devoted itself for several years to the preparation of this paper in the hope of presenting a picture of the evolutionary responses within the field of medicine to demands from a progressively enlightened people seeking fuller development of their innate capacities.

REFERENCES

SUGGESTED ADDITIONAL READING


Acknowledgments

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