Psychological Medicine, 1998, **28**, 1463–1467. Printed in the United Kingdom

BRIEF COMMUNICATION

General practitioners' attitudes to psychiatric and medical illness

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ABSTRACT

Background. General practitioners are increasingly involved in the care of patients with long-term psychiatric disorders. We have previously reported that general practitioners are less willing to treat patients with schizophrenia than those without such a diagnosis, but this may have been attributable to a reluctance to treat patients with any psychiatric or chronic illness. We, therefore, examined general practitioners' attitudes to patients with chronic psychiatric or medical illnesses.

Methods. A random sample of 260 local general practitioners were each sent one of our case vignettes which were identical apart from mention of a previous diagnosis of schizophrenia, depression, diabetes or no illness. The general practitioners were asked to indicate their level of agreement with 13 attitudinal statements based on the vignette.

Results. One hundred and sixty-six (66%) of the general practitioners responded to the case vignettes. Those responding to the vignette about the patient with schizophrenia were less happy to have that patient on their practice list and were more concerned about the risk of violence and the child's welfare. Those responding to the depression vignette were more likely to offer the patient antidepressants or counselling; and those who replied to the diabetes case were most likely to refer the patient to a hospital specialist. These differences were not attributable to the personal or practice characteristics of the general practitioners.

Conclusions. Patients with schizophrenia arouse concerns in general practitioners that are not simply due to those patients suffering from a psychiatric or chronic illness. Our results suggest that some patients with schizophrenia may find it difficult to register with a general practitioner and receive the integrated community-based health care service they require. Psychiatrists should provide education and support to general practitioners who look after patients with schizophrenia.

INTRODUCTION

The drive to community care for major psychiatric disorders is generally seen as desirable and feasible, but stereotypical and stigmatizing attitudes towards the 'mentally ill' can be major obstacles to patients' ability to re-integrate socially. These negative attitudes may be expressed by family members, friends, the general public, employers and even doctors. Medical students and doctors tend to regard psychiatric patients as difficult and unrewarding to treat (Buchanan & Bhugra, 1992), and a recent survey of those with psychiatric illnesses found that approximately one-half reported having been badly treated by general health care services and one-third complained that their own general practitioner had treated them unfairly (Read & Baker, 1996).

In a previous study, using case vignettes, we reported that general practitioners were less willing to treat a patient with a past history of schizophrenia than an otherwise identical patient without that diagnosis, although we could not

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be sure that this may have been a general attitude towards those with any chronic or psychiatric illness (Lawrie *et al*. 1996). We, therefore, sought to develop that study, by examining the attitudes of general practitioners to patients with different psychiatric and medical illnesses.

METHOD

We randomly selected 260 general practitioners from the Lothian Health Board register of primary care practitioners. We sent them, in sequence, one of four brief case vignettes that were identical apart from mention of a past medical history of schizophrenia or depression or diabetes or illness in the second sentence. The vignettes were as follows:

A 30-year-old married housewife, with a 5-year-old child, wishes to join your practice. She has a 2 year history of… schizophrenia, which has been well controlled on antipsychotics / depression, which has been well controlled on antidepressants / diabetes, which has been well controlled on antidiabetics / She has previously been in good health. She moved into your area 2 months ago, since when she has been troubled by insomnia, fatigue and nausea.

These abstracts were kept deliberately brief, both to maximize the response rate and to measure attitudes to such patients generally rather than to the specific example given. We asked the general practitioners to indicate their level of agreement (0–6, from 'not at all' to 'completely') with 13 questions based on the vignette – the questions and answers are shown together in Table 2. Finally, the doctors were asked to answer some questions about themselves, to see if factors such as age and sex influenced their attitudes. These personal details are shown in Table 1.

Statistical analysis

We used non-parametric statistics to examine whether the responses to the 13 questions on the vignettes differed across the four groups of doctors i.e. according to whether they had been allocated a patient with schizophrenia/depression/diabetes/no past medical history. We hypothesized that any negative attitudes would be most evident in those replying to the vignette about schizophrenia, followed by depression and diabetes in turn. An initial Kruskal–Wallis one-way analysis of variance was followed by *post hoc* Mann–Whitney *U* tests if an overall difference ($P < 0{\cdot}05$) was found. Finally, the effects of any differing personal characteristics across the four groups were examined, by ANOVA for continuous variables and the chi-squared test for categorical variables.

RESULTS

A total of 166 general practitioners returned usable questionnaires – a response rate of 66% as seven had moved, retired or died: their demographics are shown in Table 1. It can be seen that the four groups of doctors differed in age ($P = 0{\cdot}02$) and showed a tendency to vary in whether they had received 6 months formal training in psychiatry or not, but the other characteristics were very similar across the four groups.

The responses to the questionnaire, grouped by vignette, are displayed in Table 2 and show

Table 1. *General practitioner characteristics according to vignette group*

	Schizophrenia	Depression	Diabetes	Healthy	*P*
Responders (*N*)	38	43	42	43	—
Median age (inter-quartile range)	39 (35–47)	42 (39–50)	47 (42–50)	43 (36–49)	0·02
Sex (M/F)	23/15	25/18	22/20	25/18	0·9
Urban/rural	29/5	33/8	31/8	31/6	0·9
Median *N* of partners (inter-quartile range)	4·5 (4–7)	5 (4–7)	5 (4–7·5)	5 (4–7)	0·6
Fundholder (Yes/No)	18/20	20/22	17/25	14/29	0·4
Psychiatry experience (Yes/No)	17/21	19/24	10/32	12/31	0·09

https://doi.org/10.1017/S0033291798007004 Published online by Cambridge University Press

Table 2. *General practitioners' levels of agreement – medium score (inter-quartile range) – with statements according to vignette group*

Statement	Schizophrenia (S)	Depression (De)	Diabetes (Di)	Healthy (H)	Kruskal–Wallis *P* and *post-hoc* tests
1 You would be happy to have this patient on your list	5 (4–6)	6 (5–6)	6 (5–6)	6 (5–6)	0·03 S < De,Di
2 This person is likely to take up a lot of time	4 (3–5)	4 (3–5)	4 (3–5)	4 (3–4)	0·5
3 You would refer her to a hospital specialist	3 (1–3)	1 (1–2)	4 (3–5)	1 (1–2)	< 0·0001 Di > S > De,H
4 This patient is more likely to be violent than most patients	1 (0–3)	1 (0–1)	0 (0–1)	1 (0–2)	0·04 S > De,Di,H
5 She is unlikely to comply with advice or treatment given	2 (1–3)	2 (1–3)	1 (0–3)	2 (1–3)	0·2
6 You would be concerned about the child's welfare	3 (3–4)	3 (2–4)	2 (1–3)	3 (1–3)	0·0008 S > De > Di S > H
7 She is likely to drink to excess	2 (1–3)	2 (1–3)	2 (0·5–3)	3 (1–3)	0·08
8 She is likely to take illegal drugs	1·5 (1—3)	1 (1–2)	1 (0·5–2)	1 (1–3)	0·4
9 You would advise her to eat more healthily and exercise	3 (3–5)	4 (2–5)	4 (3–5)	4 (3–5)	0·2
10 She arouses your sympathy	4 (3–5)	5 (4–5)	4 (3–5)	4 (4–4)	0·3
11 You would personally contact her previous GP	3·5 (2–5)	3 (1–4)	2·5 (1–4)	2·5 (1–3)	0·04 S > De,Di,H
12 You would consider prescribing antidepressants	3 (2–4)	5 (4–5)	3 (1–4)	4 (2–5)	< 0·0001 De > H > S,Di
13 You would consider referring her for counselling	3 (1·5–4)	4 (3–5)	3 (2–5)	4 (3–5)	0·04 De > S,Di

overall differences ($P < 0{\cdot}05$) in the questions about: being happy to have the patient on the list, referral to a specialist, the risk of violence, concern about the child, contacting the previous general practitioner, considering antidepressants and considering counselling. *Post-hoc* testing demonstrated that most of these overall differences were attributable to specific differences ($P < 0{\cdot}05$) in attitudes to patients with schizophrenia as opposed to other groups (see Table 2). The only difference between those with depression and the controls was on the question about antidepressants, and the only difference between those with diabetes and the controls was on the question about referral to a specialist.

Finally, we examined the possibility that differences in age across the groups of general practitioners exerted an effect on the responses, with Spearman rank correlations between age and response scores, but the correlations were uniformly very weak and non-significant.

DISCUSSION

It is apparent that general practitioners are generally more negative about a patient with schizophrenia than an otherwise identical patient with depression or diabetes. In particular, they were less happy to have a patient with schizophrenia on their practice list, and were more concerned about the risk of violence and the child's welfare. These differences are unlikely to be attributable to the lower age or greater experience of psychiatry for those who received the schizophrenia vignette, as these factors would probably have tended to reduce any negative attitudes to such patients, and the other general practitioner characteristics were essentially the same across groups.

The differences are, therefore, likely to be attributable to perceived or real problems in the care of patients with schizophrenia. It is clear that patients with schizophrenia are more likely

https://doi.org/10.1017/S0033291798007004 Published online by Cambridge University Press

to be violent in general, and against general practitioners in particular, than those with other psychiatric conditions or the general population (Hobbs, 1991; Wessely *et al.* 1994). Similarly, the children of mothers with schizophrenia (and depression) are at higher risk of coming to harm than are children generally (DaSilva & Johnstone, 1981). It is also well recognized that general practitioners usually wish to receive some sort of help from psychiatrists in caring for patients with schizophrenia (Kendrick *et al.* 1991; Royal Colleges of Psychiatrists and General Practitioners, 1993), which probably explains the desire for specialist involvement and information from the previous general practitioner. It is, therefore, likely that we have replicated our previous finding (Lawrie *et al.* 1996), and extended it by showing that patients with schizophrenia are more likely to evoke negative reactions than patients with other chronic psychiatric or medical illnesses, because patients with schizophrenia are intrinsically more difficult to look after.

The question remains whether these attitudinal differences – however realistic and justifiable – would translate into any form of discrimination against patients with schizophrenia in clinical practice. Responses to case scenarios are generally regarded as indicative of likely behaviour (Finch, 1987), and it should be noted that our fictional patient was 'well controlled' on medication and that social desirability biases are common on questionnaire studies. While our findings are specifically about a new patient joining the practice list, for the sake of providing a clear experimental situation to test attitudes, we think that they are also applicable to long-standing practice patients. They are certainly relevant to the 20% or so of all patients with schizophrenia who have no general practitioner (King, 1992), as well as to those who move into a different locality, and probably to those who are homeless or have been recently discharged from hospital. Although the median response to question one was quite high, indicating a general acceptance of such a patient onto a practice list, it is certainly possible that some general practitioners would keep their contact with such patients to a minimum and perhaps refuse to treat some altogether. This view is in keeping with reports that few general practices have routine review policies for those with long-term psychiatric disorders (Kendrick *et al.* 1991); and with a recent suggestion from the General Medical Services Committee that general practitioners are duty bound only to identify psychiatric needs, rather than treat them (Kendrick & Burns, 1996). This is a particular concern given that the general practitioner is the only medical contact for a substantial minority of patients with chronic psychiatric disorders (Nazareth *et al.* 1995).

There are fewer responses of note to the vignettes of patients with depression or diabetes. The greater readiness to treat those with depression, with antidepressants or counselling, is to be expected. The suggestion that general practitioners would not treat the same symptoms as readily in diabetes or schizophrenia probably reflects the (false) perception that depression related to a chronic illness does not necessarily require (or perhaps respond to) treatment. Quite why the doctors should be more likely to seek a specialist opinion in patients with diabetes than in those with schizophrenia or depression is uncertain, particularly given the obvious concerns about patients with schizophrenia already discussed.

Given these difficulties, psychiatrists must strive to work closely with general practitioners who are looking after patients with schizophrenia, to increase their confidence in treating it, to facilitate the development of routine review arrangements and to promote reasonable attitudes towards those with psychiatric disorders in general. Although there is no specific evidence, one could reasonably expect that such 'shared care' (Royal Colleges of Psychiatrists and General Practitioners 1993) may bring about improvements in the provision of community care to and ultimately the outcome of those which chronic psychiatric disorders.

We are grateful to all the general practitioners who returned completed questionnaires.

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