Brit. J. Psychiat. (1973), 123, 185–91

A Further Study of Psychiatric Out-patient Services in Manchester

An Operational Study of General Practitioner and Patient Expectation

By D. A. W. JOHNSON

In a recent survey of the psychiatric out-patient services at three Manchester Hospitals (Johnson, 1973), the diagnoses, treatments and disposals of new patients were discussed. The survey concentrated on the psychiatrist's role in the out-patient department, whereas in fact two other important viewpoints are involved, that of the referring doctor (usually the general practitioner), and the patient. Despite the importance of these viewpoints they have been largely neglected in the psychiatric literature. Only the study of Kaeser and Cooper (1971) attempts to investigate the out-patient department from all points of view, and their findings are likely to be atypical in certain respects since 60 per cent of their patients sample were referred to an emergency clinic, and dealt with by non-consultant medical staff. The present study attempts to answer the following questions about patients referred to the psychiatric out-patient department of a provincial teaching hospital.

(1) What were the general practitioners' reasons for referral?

(2) What treatment had the patient received before referral?

(3) Who first suggested referral to the hospital?

(4) What in the patient's view was the reason for his attending the psychiatric out-patient department?

(5) What was the patient's expectation from his attendance?

Method

The study was carried out at the University Hospital of South Manchester, which includes the University Department of Psychiatry and three N.H.S. consultant firms, and fulfils the role of a District General Hospital. It embraces the area principally supplying referrals to the Manchester Royal Infirmary, and is immediately adjacent to the catchment areas of the two other hospitals included in the former survey, 'Analysis of Out-Patient Services' (Johnson, 1973).

Three consultants were chosen for this survey—the professorial firm and two N.H.S. consultants. The selection of consultants was determined only by the fact that their out-patients' sessions were held at a time convenient to the author.

The day a request was received at the hospital for an O.P. appointment, the referring G.P. (other sources of referral were excluded) was sent a questionnaire. The doctor was asked three questions concerning referral.

(1) Did he require a diagnostic opinion?

(2) Did his patient require special investigations?

- (a) psychological
- (b) physical

(3) *Treatment*

- (a) Advice ONLY—management to be continued by the family doctor?
- (b) Treatment and management to be carried out by the hospital?

The general practitioner was then asked to state his own diagnosis and the treatment prior to referral.

It was subsequently thought necessary to contact a sample of general practitioners to clarify their interpretation of the term 'psychological investigations' and also to confirm that they understood that '*Treatment*, Advice ONLY' meant advice after an initial visit and not from a series of out-patient visits. Thirty-one practi-

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

tioners were approached, but only 24 were actually interviewed.

Only questionnaires returned to the author before the patient's out-patient appointment were included in the study.

When the patient arrived at the hospital for his appointment he was interviewed by the author before seeing the psychiatrist. Not all patients included in the initial sample were interviewed, some because of their non-attendance and others because of the shortage of time. To avoid conscious patient selection they were interviewed in the order of arrival. The patient was asked who first suggested referral, what they thought was the reason for their attending a psychiatric out-patients, what their expectations were from their attendance, and details about their treatment from the general practitioner, including the number of consultations prior to attendance at the hospital.

Results

G.P. questionnaire

Of the 220 questionnaires posted, 204 were returned—a 93 per cent response rate. The returned questionnaires came from 98 different doctors.

Table I shows that a diagnostic opinion was required in 128 patients (63 per cent). Special investigations were thought necessary by the referring practitioner in the case of 94 patients (46 per cent); 88 patients required psychological investigations and 8 patients physical investigation; two required both psychological and physical investigation. It became quite clear from the doctors interviewed that the term 'psychological investigation' included talking to the patient or relatives to investigate possible psychological trauma or environmental stress.

Table I

General practitioner questionnaire

	N	%
Diagnostic opinion required	128	*63*
Special investigation required	94	*46*
(a) Psychological	88	*43*
(b) Physical	8	*4*
N = 204		
Treatment		
(a) Advice ONLY	92	*49*
(b) Hospital management	60	*32*
(c) Psychiatrist to decide	36	*19*
N = 188		

N = numbers of patients

Unfortunately only 188 general practitioners (86 per cent) recorded their views on the treatment required. Almost half the doctors (49 per cent) stated that they required 'Advice ONLY—management of the patient to be continued by the family doctor'. The doctors interviewed confirmed that this meant advice after initial attendance at the out-patients, providing (a) that the patient had been seen by a consultant and (b) that the consultant was happy to allow the G.P. to continue management. In a third of cases the G.P. was quite definite that he wanted the hospital to take over the management of the patient. The remaining fifth were prepared to leave the decision to the psychiatrist.

As Shepherd *et al.* (1966) has found that a doctor's age affected his selection of patients for referral it was thought possible it might also influence his expectation from such referrals. Table II shows the duration of qualification of (a) an area sample, (b) the G.P. referring cases to the out-patients during the period under study, and (c) the G.P.s requiring 'Advice ONLY'. The results show a significant trend for the more recently qualified doctors to be over-represented amongst those doctors actually referring cases ($p < 0 \cdot 001$). Women doctors appear to refer rather fewer cases. If the duration of qualification of G.P.s requiring 'Advice ONLY' is compared with that of the referring doctors, it can be seen that this trend is reversed. The older doctors are more likely to express a preference to retain the management of their patients ($p < 0 \cdot 001$).

Table III analyses the reason for referral in the 76 cases where the G.P. was confident of his diagnosis and did not request a consultant opinion on this aspect of the case. Nearly half (47 per cent) were thought to require psychological investigation and 11 per cent physical investigation. An investigation of the treatment requirements of this group showed that the proportion of patients that the family doctor

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

TABLE II

Duration qualified of G.P.s (a) referring patients, and (b) wishing to retain clinical control

Years qualified	Area sample (N = 94)	O.P. sample (N = 98)	Advice ONLY (N = 44)
	Percentages		
0–5	4	12	9
5–10	11	16	5
11–20	25	34	36
21–30	31	18	23
31–40	16	20	27
41–50	12	0	0
Female doctors	14	2	0

Area sample = G.P.s in geographical area of the hospital.
O.P. sample = G.P.s included in this study.
Advice ONLY = G.P.s requiring 'Advice ONLY, management of the patient to be continued by the family doctor'.

TABLE III

Reasons for referral in the group of patients where the G.P. did not require a diagnostic opinion (G.P. questionnaire)

	N	%
Investigations		
(a) Psychological	8	*11*
(b) Physical	36	*47*
Treatment		
Advice ONLY	45	*60*
Hospital management	27	*35*
Psychiatrist to decide	4	*5*

N = 76

hopes the hospital will take over for treatment is the same as for the whole sample: approximately one-third of patients. The proportion in which 'Advice ONLY' is required has risen from 49 per cent to 60 per cent.

When the treatment given before referral was investigated (Table IV) it can be seen that the G.P.s recorded 'None given' in 89 cases (44 per cent). In the opinion of the referring G.P. psychotherapy was given to 6 per cent and social help to 2 per cent of patients. Medication was the principal form of treatment (48 per cent). Two-thirds of patients who were given medication had drugs described as anti-depressants. An analysis of patients referred without prior treatment shows that a third were not diagnosed at the time of referral, and most of the remaining patients had either personality disorders or social problems.

TABLE IV

Treatment prior to referral—all patients (G.P. questionnaire)

	N	%
No treatment given	89	*44*
Psychotherapy	12	*6*
Social	4	*2*
Medication	99	*48*

N = 204

Two-thirds of patients treated with medication were prescribed drugs classified as 'anti-depressants'.

Patient interviews

The age and sex of the 105 patients interviewed is shown in Table V. The usual preponderance of female patients found in psychiatric out-patients (Johnson, 1973) is confirmed. Kessel and Shepherd (1962) have previously commented that age is an important variable in the referral of patients to hospital—younger patients being referred more frequently, which is the opposite to the morbidity found in general practice. This observation is also confirmed.

In one third of cases the initial suggestion that the patient should be referred to a psychiatrist came from either the patient or a close relative (Table VI); in 14 per cent of cases from the patient's marital partner—the patient usually being a man in his twenties or early thirties, and

TABLE V

Patients interviewed

Age in years	Sex: Male	Sex: Female
20 or less	6	12
21–30	15	12
31–40	10	15
41–50	3	14
51–60	0	3
60 or more	6	9

N = 105
Female to male ratio: 1·6 to 1

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

TABLE VI

Who initially suggested referral?
(patient interview) percentages

G.P.	51
Other doctor	9
Patient	17
Husband or wife	14
Other relative	3
Social worker	6

N = 105

in 3 per cent of cases from a parent with a teenage child. Although in 60 per cent of cases the first suggestion came from a medical source, the general practitioner was the instigator in only half of the total patients referred. Social workers suggested referral in 6 per cent of patients.

When the reason for their referral was discussed with the patients, only 66 per cent would admit that they *might* have a psychological or emotional illness (Table VII). Eleven per cent thought they had a physical illness; 23 per cent did not regard themselves as ill and did not see the psychiatrist as fulfilling a medical role.

When the patient's expectation from the psychiatrist was investigated, it was found that in one third of cases the patient expected a cure, meaning a traditional medical type treatment leading to complete resolution of symptoms. In 40 per cent of patients the expectation was of some definite help but not of a complete cure in the medical sense. In 17 per cent of cases the patient did not expect the psychiatrist to be of any particular help; the principal reason stated was that the psychiatrist did not have the appropriate help to offer.

TABLE VII

Reason for referral (patient interview)—percentages

Might have psychological or emotional illness		66
(a) acknowledged psychiatric illness	46	
(b) possible emotional cause	14	
(c) drugs (including alcohol)	6	
Physical illness		11
Not ill		23
(a) social problems	11	
(b) other reasons	12	

At the time of attending the hospital 68 per cent of patients were receiving treatment, compared with 56 per cent at the time of referral. No patient regarded himself as being given or offered psychotherapy, but 3 per cent acknowledged some form of social help.

Perhaps the most surprising result is that 11 per cent of patients had not seen their family doctor before referral (Table VIII), although the referral letter gave no clue to this fact. Most of these patients had been seen by either another hospital doctor or a social worker who had suggested referral to the general practitioner. A further third of patients had seen their family doctor only once at the time of referral. In contrast 34 per cent of patients had received fairly intensive treatment involving in some patients numerous and regular consultations.

Patient disposal

The disposal of the patients interviewed followed closely the pattern found in the previous larger study (Johnson, 1973). Sixty-eight per cent of patients continued treatment at the hospital under the psychiatrist either as an in-patient or an out-patient, a further 3 per cent were referred to the hospital social work department for help. Twenty-three per cent of patients were returned to the care of their general practitioners, 9 per cent with advice on treatment, 14 per cent stating that no psychiatric treatment was required.

DISCUSSION

It must be remembered that this survey was of consultant psychiatrists' new-patient clinics with an average waiting period of three weeks. In

TABLE VIII

G.P. consultations before referral (patient interview) percentages

Consultations	
0	11
1	32
2	11
3	9
4	3
5 or more	34

N = 105

No correlation with age, sex or marital status

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

these circumstances it is quite clear that almost half the general practitioners were asking for a diagnostic opinion and investigations resulting in advice on treatment, but allowing the general practitioner to continue the management of his patient. Only one third of doctors specifically wanted the hospital to take over the patient's management. This contrasts with Kaeser and Cooper's conclusion that 'in the main the general practitioner wanted the hospital to take over clinical responsibility, the demand for consultant advice being relatively small' but is not so very different from their analysis of the expectation from the consultant clinic, where 45 per cent of general practitioners expected in-patient or out-patient care for their patients, with a further 7 per cent requiring assessment. The present survey would suggest that the provision of a consultant diagnostic opinion followed by advice on treatment would meet the expectation of the general practitioner in over half the cases referred to out-patients. Shepherd *et al.* (1966) found that almost all the survey doctors insisted that the treatment of minor psychiatric illness was part of the proper function of the general practitioner. The fact that consultants took over the direct responsibility for the continuing care of 90 per cent of ill patients, even though in 50 per cent of cases they did not offer any form of treatment that was not equally available in general practice (Johnson, 1973), cannot be explained only in terms of general practitioner expectation.

The results would seem to suggest that in a substantial minority of cases the general practitioner regarded the consultant out-patient service as a source of primary care or advice. In 44 per cent of cases the patient had not been prescribed any treatment at the time of referral; 43 per cent of patients had either not been seen at all, or only once before referral. A further pointer was that many of the general practitioners who stated that further psychological investigations were required (43 per cent) were in fact only asking for a detailed history from the patient or family. Although some of the doctors interviewed regarded psychiatric history taking as requiring special expertise it was quite clear that most thought that the psychiatrist had more time.

The important influence of relatives upon psychiatric referral has been commented upon before. Richards (1960) found one third of referrals initiated by the patient or relative. Rawnsley *et al.* (1962) found relatives of similar importance in South Wales. Kaeser and Cooper (1971) found 25 per cent of referrals initiated by the patient or relative, and that this pattern was more common among male patients. This survey confirms the importance of the patient's own decision and the influence of relatives. It further illustrates that the group most influenced by relatives consists of young husbands who are urged to attend the psychiatrist by their wives.

The validity of the often-repeated statement that the proper psychiatric training of general practitioners will reduce the work load of the psychiatrist is questioned. In fact the general practitioners initiated referral in only 51 per cent of cases. Susser (1961) showed in Salford that most psychiatric referrals came from specially interested general practitioners. In studying the duration of qualification of (a) doctors referring cases, and (b) the separate groups of those who wished to continue management and those who preferred the hospital to take over treatment, it becomes clear that the trend is for the more recently qualified doctors to refer more patients, and for this same group of doctors to be more reluctant to continue management. With the recent emphasis on psychiatry in medical undergraduate teaching, and an equal opportunity for post-graduate training for doctors of all age groups, it would seem unlikely that psychiatric training alone would explain this trend. Shepherd *et al.* (1966) concluded that the determinants of psychiatric referral were probably complex, and related to a number of independent variables.

Two-thirds of the patients attending hospital recognized that their complaints might be the result of a psychiatric illness, or at least emotional in origin, but a not insignificant minority (23 per cent) did not regard themselves as ill or emotionally upset, and did not regard the psychiatrist as being in a 'medical' role. They required help or advice in marital or social problems and believed the psychiatrist to have the expertise, or to be able to call upon the

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

appropriate agencies, in these spheres. Perhaps this is what Kessel (1963) meant when he said psychiatry has tended to oversell itself.

As commented by Kaeser and Cooper, the expectations of the patients were relatively low; only a third thought the psychiatrist would cure them, though a further 40 per cent expected some help. The expectations were also fairly realistic, since few of the patients with personality disorders or social problems expected a cure. The group of patients who expected a cure were nearly all suffering from either a depressive illness or sexual difficulties; most of the latter group had either read or been told that psychiatry could solve their particular difficulty.

An analysis of treatments offered by the general practitioners once again confirms that medication is the principal treatment offered in general practice—as it is in hospitals (Johnson, 1973). Psychotherapy was offered to 6 per cent of patients, but none of the patients themselves thought they had received any psychotherapeutic help, and only 3 per cent thought they had received any specific social help. There were enormous differences in the treatment that patients received from different doctors. It is quite clear that approximately one third of general practitioners had referred their patients only after their own enthusiastic treatment had failed; on the other hand a slightly larger group of doctors appeared reluctant to investigate or instigate treatment; this reluctance had no correlation with the treatability of the patient.

It is also clear that the psychiatrist's policy of taking over direct responsibility for the continuing care of most ill patients referred is not dictated by the expectation of the general practitioner. Further, the referral of patients, sometimes without consultation, to the psychiatric out-patients for primary care, or before a proper therapeutic trial of treatment, places an unnecessary burden upon the hospital specialist. More intimate contact between general practitioner and psychiatrist during both undergraduate and post-graduate training will, no doubt, lead to an increased expertise in the family doctor and an awareness of the correct potential of the psychiatric out-patient service. This will not, however, solve the problems that hinge on communication. It has been suggested that a more personal contact could be achieved between family doctor and specialist in a community-based service, perhaps with sessions in group practice health centres. This must remain an unfulfilled dream with the present shortage of trained psychiatrists trying to satisfy a rapidly expanding demand. The use in common of modern post-graduate centres will improve the personal rapport between family doctor and psychiatrist in some cases, resulting perhaps in an improved exchange of information. However, it is likely that the most immediate gain would come from the proper use of the traditional forms of communication between hospital and surgery: the telephone and referral letter. A clear statement of expectation from the hospital should be included with details of history and treatment in the referral letter. If the patients are referred back to the family doctor for management, the psychiatrist must be more readily available, as under such circumstances a waiting period of three weeks before a further out-patient consultation is quite unacceptable.

Summary

A survey of G.P.s referring patients, and of patients attending the psychiatric out-patient department suggests that approximately half the patients are referred for a diagnostic opinion or investigations, and a third for the hospital to take over management of the patient. It seems quite clear that between one third and one half of family doctors are using the out-patients as a source of primary care or advice, without first treating or investigating their patients. Some doctors use the clinic in this way because they regard the psychiatrist as having more time to interview the patient or relatives. There is also some reason to suspect that the more recently qualified doctors tend to refer more cases to the hospital, and prefer the hospital doctors to supervise their future management.

The importance of influences other than the family doctor in the referral of a patient is emphasized. On the whole the expectation of the patients from treatment was low and in most cases realistic, but a minority of patients attended the out-patient department with the

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press

sole expectation of social help rather than with any emotional or psychiatric distress.

References

JOHNSON, D. A. W. (1973). 'An analysis of out-patient services.' *British Journal of Psychiatry*. 122, 301-6.

KAESER, A. C., and COOPER, B. (1971). 'The psychiatric patient, the general practitioner, and the out-patient clinic: an operational study and review.' *Psychological Medicine*, 1, 312–25.

KESSEL, W. I. N. (1963). 'Who ought to see a psychiatrist.' *Lancet*, *i*, 1092–5.

KESSEL, W.I.N., and SHEPHERD, M. (1962). 'Neurosis in hospital and general practice.' *Journal of Mental Science*, 108, 159–66.

RAWNSLEY, K., LOUDON, J. B. and MILES, H. L. (1962). 'Factors influencing the referral of patients to psychiatrists by general practitioners.' *British Journal of Preventive and Social Medicine*, 16, 174–82.

RICHARDS, H. (1960). 'Psychiatric referrals from general practice.' (Unpublished dissertation.) University of London.

SHEPHERD, M., COOPER, B., BROWN, A. C., and KALTON, G. (1966). *Psychiatric Illness in General Practice*. London: Oxford University Press.

SUSSER, M. W. (1961). *Report on Mental Health Services of the City of Salford*.

A synopsis of this paper was published in the January 1973 *Journal*.

D. A. W. Johnson, M.Sc., M.R.C.Psych., D.R.C.O.G., *Lecturer in Psychiatry, University Hospital of South Manchester, Manchester M20 8LR; now Consultant Psychiatrist, Crumpsall Hospital Manchester M8 6RB.*

(*Received 8 August 1972*)

https://doi.org/10.1192/bjp.123.2.185 Published online by Cambridge University Press