*The contribution of modern psychiatry to the general practice of medicine**

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Inspection of the number and kinds of post-graduate courses in psychiatry offered to American general practitioners shows a difference from courses in other medical disciplines. As compared with those offered in medicine, surgery and their subdivisions, they are limited in number and scope. Few American university medical centers are engaged in conducting these courses — (*1959*) *J. Amer. med. Ass. 170, 1977; (1960) Idem 173, 1713.*

It may be useful to study the reasons for this in order to learn whether they reflect underlying differences in substance and in method in the teaching of psychiatry to general practitioners from the post-graduate courses in medicine and surgery. This appears to be a necessary and sensible thing to do as it is widely agreed that medicine, as an applied science, must be cumulative. Regardless of how thorough and painstaking the physician's basic medical education and his subsequent hospital training may have been, few, if any, would defend the position that these experiences are sufficient to master all relevant knowledge, or that the physician will grow further in his scholarship and skills only through his personal unshared experience. In most nations the practicing physician is encouraged to read and study continuously the scientific advances reported in medical journals and monographs; he is invited to attend and to participate with his peers in local, sectional and national professional conferences; he is offered opportunities to take part in special courses designed to meet his interests and needs.

Furthermore, as medicine moves away from its restricted concern with the hospital towards the community and towards matters of prevention and the maintenance of health, it is becoming increasingly apparent that the general practicing physician has much to contribute to medicine as a whole. In my view the usefulness of his contribution will stem principally from his experiences in his idiosyncratic theatre of operations. He is in the unique position of being able to add immeasurably to our store of information and to correct our misinformation about the incidence and prevalence of disability due to illness, and of the success or failure of old and new physical, chemical, psychological, and social methods of treatment applied by himself and other physicians in their care of the sick. More important, if he is alert, informed and interested he may help to accumulate the facts necessary to establish a more accurate conception of health and illness, perhaps, even to learn more clearly the nature of the human family, its strengths and weaknesses, and the effects of such on the promotion of health and the development of illness in one or more of its members.

Is it necessary at this time to defend the need for special courses in psychiatry to general practitioners in addition to the courses offered him in medicine, surgery, anesthesia, cardiovascular disease, allergy and a host of other special medical disciplines? Is it possible one day that the role of the general practitioner will become such that knowledge of the principles of modern psychological medicine will not be of fundamental importance for his work; that there will be knowledge available for those with special intrests or needs but not really considered essential for all?

I think this unlikely even though I am aware that there exists now and will continue to exist significant differences between nations and between sections of nations in the design and operation of the general practitioner's work. These differences stem in part at least from underlying social and economic patterns of health care in various nations, from the perceptions of bodies of organized medicine of their functions to the societies in which they live and work, and from the basic medical education and hospital training of the physician.

I am also aware of the difference in incidence and prevalence figures of the number or percentage of patients seen by general practitioners in their daily practices who are described as having significant emotional or mental problems determining or modifying their illnesses. My impression is that a number of these reports pay little attention to the question of the reliability of the instrument used which in great part must include the degree of interest, the knowledge and psychological perceptiveness possessed by the physician himself. Granting the oversimplification of the comparison, imagine the results of studies of patients with hypertension or with syphilis if some observers were acquainted with and used properly the sphygmomanometer or the complement fixation tests in determining prevalence and others were ignorant of their existence or used them improperly. It is hoped that in the future such studies will be done with more attention to the relia-

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bility of the observer and perhaps include cross checks with multiple observers. My experience and observations in the United States, the United Kingdom and in Europe lead me to believe that the physician does have a special contribution to make to modern society. Today he has an unusual opportunity to obtain a sound scientific training, to develop attitudes of critical perceptiveness and to become informed.

His basic medical education allows him to bring to the patient-physician relationship what Parsons has described as an affectionate and moral neutrality (*Parsons*). With this he is able to understand more clearly his role of attempting through insight and sympathetic understanding to study and help his patient but without becoming a censor or a judge. Tomorrow, like today, patients will come to him; children, some psychotic patients, prisoners and soldiers may be brought to him. Those who come will do so because of the pain, anger, fear, and special kinds of fear we call anxiety, shame and guilt within them and because of the social disability which ensues from these in their illness. They will come with varying degrees of trust and confidence, and with the wish and the expectation that they will obtain relief, if not understanding.

Their distress will be variously manifested, the spectrum of underlying disease will continue to be characteristically broad. It is essential that the physician be adequately informed in order to identify early, to prevent if possible, treat intelligently and effectively what is within his skill to influence and to ask for help from others when indicated. But if he is to deserve this position in modern society and if he is to fulfill his responsibilities he must have the training and education which is appropriate to his work. If, on the contrary, through design or neglect he is to perpetuate the dichotomy of the current belief system of dealing scientifically and systematically with man's body but remain content to deal artistically and intuitively with man's mind, his emotions and their relationship to the body in health and sickness, to the family of which the patient is a member, and to his relations as physician to the patient, he will indeed be found wanting.

Are not the personal and interpersonal, the human aspects of man equally subject to scientific scrutiny as have been the less personal behavior of his metabolism? How else can the physician of tomorrow become informed, how else can he hope te behave intelligently and work effectively? Before we proceed further with the question of substance, that is what attitudes, what knowledge, what skills are essential to the physician of tomorrow, let us return for a moment to a point of pedagogy, namely to the differences we drew attention to earlier.

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Some time ago I wrote in effect that our experience in the United States led us to believe that there are special difficulties in short-term, refresher or post-graduate courses in psychiatry for practicing physicians (*Romano*). Further, we believe these difficulties were different from those encountered in similar types of short-term or refresher courses presented to practicing physicians in the subject matters of the other clinical medical disciplines. Currently in the United States there is a wide variation in the teaching of psychiatry to medical students in the undergraduate medical period. An increasing number of schools have made great advances in their teaching programs and later I shall discuss some of the factors responsible for the growth in prestige and status of the teaching of psychiatry in our medical schools. Although the general movement is towards improvement we continue to be impressed with a considerable degree of unevenness in the psychological perceptiveness of students from various schools, together with differences in the systematic knowledge accumulated and the skills exhibited by them in the study and care of their patients. Even greater variations exist in opportunities for psychiatric education in the first year internship and house officer programs throughout the hospitals in the United States. I believe this is quite different from the situation which exists in the teaching of medicine, surgery, pediatrics and obstetrics, where a much greater degree of uniformity in knowledge and skills is shown by students from different schools and hospitals. Recent observations lead me to believe that this is not the case in the United Kingdom and in Europe. Although the students with whom I met also show a considerable degree of unevenness in their psychological perceptiveness, as a lot, they are much more homogeneous in that few, so far as I could determine, have had any systematic instruction in the principles and practices of psychological medicine as these are currently being taught in a number of medical schools in the United States.

From our experiences in the past twenty-five years in teaching medical students and house officers in a number of medical schools and hospitals we have learned that the teaching and learning processes in psychological medicine necessitate reorientation of one's perception of oneself, of the patient, and of other persons in the physician's or students' and the patients' worlds. We have found, too, that this cannot be taught or learned within a compact concentrated time schedule, nor can it be taught exclusively through didactic lectures or through reading. It requires, as does all learning, sufficient motivation on the part of the student to master the anxiety generated by facing new and different emotions, of perceiving his, his patients', and his patients' families' problems. It requires incentives, equally necessary for effective learning of the acquisition of new knowledge in his mastery of skills in understanding his patient and in helping his patient to be relieved of his distress; in short in the promotion of greater effectiveness as a physician. This methodological problem is apt to be conceptually different from the student's or physician's previous conception of his role. It involves operationally the transaction be-

tween the patient and the student or physician. It usually requires continuous, long-term clinical responsibility by actively participating in the care, understanding and treatment of the sick; the student or physician cannot be a spectator; he must be engaged, must be responsible and must be involved. We believe also that in this he needs skilled and vigilant supervision by senior teachers who meet with the student and his patient and help the student by example as well as by precept in order that the student may further develop critical perceptiveness, that is the capacity to observe carefully and to draw inferences appropriate to the data accumulated.

Is it sufficient to provide the student-physician opportunities through his transactional experience with his patient under skilled supervision to gain awareness of his emotional blind spots, to become aware of the dynamic exchange which occurs between the patient and him? What about substance? Is there any information, any knowledge in addition to the above which is important and useful? We believe there is. However, our experience again has taught us that teaching methods must be adapted properly to the material taught. Matters concerning the growth and development, decline and involution of the human personality in the family set cannot be dealt with in the abstract alone. Nor can, for example, the experience of human grief. Through the cumulative personal experience of the student and physician he is able to reach towards broader conceptualizations. Medicine cannot remain a body empiric. It must constantly point towards broader conceptualizations of data.

For these reasons we are reasonably convinced that short-term courses in psychiatry, by themselves, are limited in value. This is particularly true if such short-term courses attempt to acquaint its students with the principles and techniques of psychotherapeutic skills, whether these be in the areas of prevention, first aid, support and more particularly in anxiety-provoking insight psychotherapies. Unlike the other clinical disciplines short-term courses in psychiatry are apt not to be logical extensions of or amplifications of systematic knowledge or acquired skills which the practicing physician already possesses. This does not mean that the physician has not accumulated skills in understanding human behavior and in dealing with his patients. It is that his knowledge in this matter is less systematized, more intuitive, and more subject to the speciousness of small samples as contrasted with his more systematic knowledge in the more impersonal aspects of medicine. Thus, I believe we must look to methods other than the short-term courses to assist the general practitioner in the furtherance of his education. The fact that short-term courses for the most part are not effective should not be disheartening. I believe it should lead us to study more carefully the image or model of the general practitioner. What is his preparation to be? What are to be his roles, his daily operations, his responsibilities in modern society? What information, what knowledge, what skills will he need in order that he may continue to grow, to enjoy real and mature satisfactions in his work and to become an effective and useful contributor to society? In the study of any program of action attention must be directed to what can be done at the moment and also to what should be done in the future.

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With your permission I should like to reverse the issues in order first to outline briefly certain basic essentials in the teaching of psychiatry to medical students as part of their general medical educational background regardless of their eventual destinies as physicians. Following that I shall discuss certain areas of responsibility which I believe to be relevant to the work of the general practitioner and also to outline certain methods which could be used to help the physician acquire the knowledge and skill appropriate to these responsibilities. My reasons for doing this are that although my personal interests in the teaching of the general practitioner have been long and continuous, the greater part of my practical experience over the past twenty-five years has been in the teaching of medical students and in the preparation of young men and women destined to become career psychiatrists. Wisely or unwisely, about twenty-five years ago we made the decision in the face of limited time, persons and resources that the most useful contribution we could make at this time in the history of medical education was to devote ourselves primarily to the teaching of psychological medicine to our medical students, the physicians of tomorrow. This was done with full realization of the interests and needs of the general practitioner group.

In a number of ways we have participated in certain types of educational experiences directed towards their needs in the form of the Minnesota Experimental Course of fifteen years ago and of numerous short-term exercises in civil and military hospitals in the United States and Europe — (*1947*) *Teaching psychotherapeutic medicine, an experimental course for general physicians. The Commonwealth Fund, New York.* In addition, for the past fifteen years we have been engaged in an intensive liaison teaching and research program within our university hospital with the members of our sister departments of medicine, pediatrics, and obstetrics. (*Wilson a.o.; Engel a.o.*). Informally we have kept in touch with the general practitioners who entrust their patients to the care of our faculty in our university general hospitals. Through them we have learned much, and we in turn have invited them increasingly to share in the responsibility and care of their patients and in the teaching of our medical students. More recently I have had the opportunity of attending a number of sessions in the London Tavistock Clinic group devoted to the teaching of general practitioners and have also spent a number of days in London with them in their daily practices

of visiting and caring for their patients in their patients' homes and in the surgeries of the physicians.

But, let us return for a moment to our medical students. In the past twenty-five years in the United States there has been considerable growth in the status and prestige in the teaching of psychiatry to medical students; undoubtedly, like all complex phenomena, there are multiple determinants. It would be presumptuous to indicate that the following explain fully the reasons for this change. However, I offer them to you for your consideration, as I believe they may be contributory. Understanding of them may be of help to others, particularly to the faculties of medical schools, to administrators and others engaged in planning future changes in medical education. Due attention obviously must be drawn to sectional and national differences.

Constant concern with education, although with varying intensity, is an American characteristic. Current interest, stimulated to some degree by the Sputniks and the population expansion, ranges from the study of preschool nurseries to the highly technical schools in our universities. Medical education shares vigorously in this concern. Recently (1959) an advisory group to the Surgeon-General of the United States Public Health Service submitted their report, „Physicians for a Growing America", to answer the question. How shall the nation be supplied with adequate numbers of well-qualified physicians? In the program recommended they stress the need to safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians. Many if not most faculties of both public and private medical schools, together with others, are currently engaged in the studies of the preparation of students for medicine, of selection procedures for admission to medical schools, of curricular matters as they relate particularly to the integration of teaching between disciplines; of provisions for the research activities on the part of both students and faculties; of the assessment of students in operational as well as in traditional examination procedures; of inquiry into teaching methods and into the characteristics of successful teachers; there are even a number of intrepid, courageous souls who are trying to measure the success or failure of medical education; that is to assess the results of our medical teaching by learning what it is the physician does; how, when, where and how effectively does he do it (*Peterson a.o.*). We are also concerned with experiments in clinical service, that is in the earlier identification of the sick, of first aid facilities, of experimental day and night care services in hospitals and in the emergence of new types of clinical and hospital organizational programs. There is a trend toward a more intimate relationship between the hospital and the community in which it lives and which it serves. Conceptually in biology as a whole, as well as in medicine, there is increasing recognition of multiple causes and effects, of open rather than closed systems, of dynamic steady states in biologic systems rather than fixed immutable equilibria. This in brief constitutes certain characteristics of the climate of American medical education today.

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Let us consider now the emergence of psychiatry itself. Two sources of origin have been ascribed to the mental health movement in the United States. The first with which we are most familiar as physicians has grown up with the traditional Hippocratic form of reference based on the values of the preservation of life, the relief of pain and suffering and the reduction of social disability due to sickness. The second, perhaps less recognized source, has sprung from the roots of western humanism. It is concerned with the growth and the development of the individual. It believes that through the application of scientific knowledge about human beings and their social environment it may be possible for man to live more fully, more maturely, more creatively — *Sanford, F. H. (1957) Paper presented at National Health Forum, Cincinnati, Ohio.* I believe one can add to these a third, namely the source of a scientific discipline by and of itself, its interest being primarily in the pursuit of knowledge for its own sake without considering its immediate or eventual usefulness. It may be interesting to speculate on the reasons for the vigor and development of the mental health movement in the United States as compared with its growth and development in Europe. Perhaps it could be looked at in the broader sense, that is, in the context of the social sciences, including psychology as a whole. De Toqueville over a century ago remarked on the pragmatic climate of the American scene; much of the philosophy of Pierce, James and Dewey have given further evidence of the accuracy of this penetrating observation so many years ago (*Witenberg a.o.*). Our high standard of living, our relative freedom from the ravages of disease, our greater freedom from fixed tradition, the speed and volume of communication; these have been attributed by others as possible reasons for the vigorous development of the social sciences and psychology in our country. Perhaps our naivete, our optimism and our belief in the modifiability of man play a part. We believe that man is educable and through natural cause and effect views of human behavior, man is able to think, to apply knowledge, to solve problems and to advance his own welfare. More specifically the growth of psychiatry has also been affected by the experiences of many American physicians in World War II who, through the urgency and horror of war became more aware of the significance of psychologic and social events as determinants of human illness.

The recognition by our federal government of the magnitude of the problem of mental illness led our seventy-ninth congress in 1946 to enact the national mental health law which provided the administrative medium for monies to be allocated for the

education of psychiatrists, social workers, psychologists and nurses; for the initiation and support of new researches in the broad field subsumed by mental health and illness; for grants-in-aid to state governments for certain types of new clinical services and mental health administrative organizations. In my view the federal program, now fifteen years old, has been the single most useful influential force in the growth and development of psychiatry in the United States.

At state, county and local administrative levels there appears to be increasing recognition of the magnitude of the problem of social disability due to mental illness and various approaches have been begun in areas of prevention and rehabilitation as well as in hospital custody and treatment. Parallel but independently there has also been a rapid increase in the establishment of psychiatric units of clinical service in general hospitals, including university teaching general hospitals. This has reduced materially the separatism and isolation of the psychiatrist and his co-workers from the major theatres of medical teaching and research.

Although there remain certain realistic difficulties in the operational relations between a number of American psychoanalytic institutes and university departments of psychiatry, there is little question, from a comparative view of England and Europe, that we have reached a much more effective, intimate, and hopefully fruitful association between a number of institute staff faculties and the faculties of the university departments of psychiatry. University departments of psychiatry have grown vigorously in the past fifteen years in the number of full-time senior appointments, in the areas of clinical service for which they are responsible, in the range of research interests and activities, in the quality and number of candidates who apply for career education, in the intensity and design of their teaching programs, both undergraduate and graduate and in their studies of new methods for patient care. Much of this expansion with perhaps few exceptions in my view, as I indicated earlier, has been made possible by the introduction of federal grants for teaching and research.

Increase in the number and improvement in the quality of the candidates for career training in the field of psychiatry are again due to a number of factors. One among them which I believe to be significant is the physical presence and active participating membership of the psychiatric faculty within the major teaching hospital scene. Through his teaching, his research activities, his day-to-day clinical services, the psychiatrist serves as a model, among other models in the faculty, including the internist, the surgeon, the pediatrician and others for his students. On this basis, each student, depending on his interest, aptitude, intelligence and the opportunity afforded him can elect to search for and eventually establish his own identity from the various models of scientists and physicians with whom he will be associated. It is hoped that this will be done consciously and intelligently without recourse to blind, neurotic allegiance and its subsequent restrictions. Another characteristic of a number of American university departments of psychiatry is the development of broad eclectic interests in various bodies of knowledge and in different skills among its representatives. Although the dichotomy of the psychophobe and the biophobe are not unknown to us, there is an increasing number of university departments in which research with biochemical, neurophysiologic, psychologic, clinical psychiatric, psychoanalytic, social, genetic and epidemiologic techniques and knowledge take place in parallel, at times interrelated and often fruitful relations. Finally, in this account of the development of modern psychiatry in the American medical scene I should mention what could be called a territorial matter, namely a territory of interest and of responsibility. In the teaching of our students the department of psychiatry traditionally, inevitably, and quite properly in our minds is responsible for teaching about the psychotic patient. How can his behavior be understood, how can the patient and his family be helped? We share as fully as we can with our students existing knowledge of the causes and determinants of psychotic behavior, of currently useful therapeutic approaches, of the course and prognosis of the general impact of these problems on the patients' families and on the community in general. Our students have intimate opportunities to be responsible directly in their study and care of psychotic patients, but we are not restricted exclusively to this important area of medical experience. We have also been engaged many times alone, occasionally together with representatives from our sister departments of medicine, pediatrics, and preventive medicine in attempting to formulate and to develop a basic science of human biology. This ambitious, if not over-ambitious, goal is being done by persons such as myself who are fundamentally clinicians and not biologists, psychologists, pedagogues or social scientists. Furthermore we are trying to do this in a scene hardly contemplative but in the tumult of a clinical department engaged in teaching and research and intimately and at times oppressively involved with service to the sick and to the community at large. In this groping towards a more satisfactory concept of human biology we are concerned with matters of significance to all of medicine. For example may I mention our concern with the total functioning of the whole organism in a multiple-person field, of the ubiquitousness of emotional experience in all sick people, of the unique properties of the patient-doctor relationship, of the psychology and sociology of illness and convalescence and of the basic principles in history-taking. This leaves me to outline briefly to you the basic points of the objectives of our teaching program for medical students. I believe that with certain modifications to be discussed later the points to be made are applicable to the general practitioner as well as to the medical student.

First and foremost we do all we can to foster the growth of the student's capacity for critical perceptiveness. By this I mean his capacity to be sceptical, to question, to subject evidence to his own inquiry and to his and others experience, in short for him to be critically informed. Through these means we believe he may be better able to accumulate his own personal library of experience which he can subject to constant check whenever appropriate.

The second goal is the need for understanding the sequence of events in human growth and decline in our society with attention to genic and experiential factors as determinants. There is need in this context to learn something of the emergence of man from his early parasitic dependence to his increasing capacity for interdependent behavior; to know something of the multiple-person field, of the nature of family and group structures; also to learn something of the more frequent normative emotional crises in family and group life in our society.

The third goal is the need to have some understanding of the historical development of concepts of health and disease as mentioned earlier, in terms of multiple causes and effects, of open rather than closed systems, of dynamic steady states rather than fixed immutable equilibria.

There is need for understanding of the unique reciprocal characteristics of the relationship between physician and patient, and of the physician's reciprocal relationships to nurses, technicians, social workers, health visitors and others with whom he is associated in the care of the sick.

There is need for knowledge concerning the psychology and sociology of acute illness, chronic illness, convalescence, disability and the special problems of surgical intervention, amputation, child bearing, the care of dying persons, and the understanding of the impact of such experiences on the family members and again in the reciprocal effects on the patient. There is need to learn to diagnose correctly emotionally and mentally sick persons who express their distress in physical, psychological or social terms. This implies reasonable mastery of methods of physical examination, of psychiatric examination and the use of critical interpretation of adjunctive methods such as physical and chemical tests and psychological examinations. It also implies the reasonable understanding of matters not yet fully substantiated, namely the zones of healthy and sick behavior in our society and more particularly the ability to distinguish between normal, neurotic, psychopathic, psychotic and intellectually defective behavior.

Eventually one must acquire the ability to interview, that is to conduct a good medical history, in order to obtain pertinent data concerning psychologic and social aspects of behavior in patients who may or may not present directly symptoms of psychologic distress. This implies a comprehensive understanding of what it means to interview a patient, regardless of what his presenting problems may be.

There is need for understanding of what the physician who is not a psychiatrist can do and should do:

a in the management and treatment of emotionally healthy people who get sick;

b in the management and treatment of emotionally sick people who may or may not have physical symptoms;

c in the understanding, management and treatment of the patient in whose family certain normative emotional crises are being experienced;

d in the emergency management of disturbed patients, particularly those who frequently come to the attention of the general physician, such as the anxious patient, the delirious patient, the suicidal patient, grief-stricken patients and relatives, the excited patient, the depressed patient, the aged and the demented patients.

Equally, there is need for understanding of what the general physician cannot do and should not do in the care and treatment of the mentally sick. He must have knowledge of methods of intelligent referral to specialists, hospitals and clinics; of the scope, limitations and inter-relationships of his role as a physician and between himself and the psychiatrist, social case worker, psychologist, nurse, occupational therapist and others who care for the mentally sick; and of a realistic appraisal of the scope and limitations of modern methods of treatment of the mentally sick.

Finally, there is need for knowledge of those community resources which can be extensions of the general physicians' care of his patient, both in urban and in rural areas, social, welfare, legal and judicial agencies, the clergy, special institutions for the chronically ill and community, state and federal health programs and facilities.

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Earlier I indicated that a great part of my experience has been with medical students. It should be self-evident that there are certain problems in the teaching of modern psychiatry to medical students. As we teach in each of the four years, we meet our students at the beginning of their first year when they are twenty-one or twenty-two years of age. While they are young and inexperienced, they are older than the English and European student who enters medical school about two to four years earlier. Most of our students are college graduates, many as yet have not earned a living and although there is an increase in the incidence of marriage in students coming to the medical school and of those being married during the medical school, a number have not had an established sexual relation in marriage. Our students face the special problems of their age and time, including those of establishing their identity, problems of relationship to authority, problems of the management of sexual excitation and of being engaged in acquiring the knowledge and

skills of their profession. All students have been children, some have been patients, and some have had friends and relatives as patients. An increasing number have had various types of learning experience in psychology and social science and humanities in their collegiate preparation for medicine. For many this is the first time that they begin to deal with certain aspects of human behavior in terms different from what had been previously dealt with by them privately and personally. They will be concerned with problems concerning anxiety, fear, shame, anger and guilt. It is not unexpected that with an adolescent crust remaining their inner psychic metabolism at times is so occupied with their own problems, such as those concerning vocation, marriage, parenthood that not too much is left over to deal with the harassing and enervating emotional problems of others. It is also well known that there is much inertia and resistance to change in one's private psychological world as contrasted with the relative ease in adding to or modifying one's private accumulation of knowledge of the physical world.

There is the persistent and pervasive belief that there is something incompatible between the exercise of intuition and the acquisition of conscious knowledge, particularly when one begins to be concerned with those areas of human behavior highly invested with emotional feeling, rational and irrational, such as in the up-bringing of children, of sexual behavior, of aggression towards loved people, of differences in value systems between peoples. However, in our experience over many years dependent upon certain pedagogic methods, these matters are neither insuperable nor disabling to our students; that there is restlessness and curiosity and concern is apparent. We consider this to be one of the proper functions of the university, to stimulate each student to examine his information, his knowledge, his prejudices and beliefs, to compare and contrast them with other points of view so that eventually he can point towards a more conscious, more informed, more understanding self and subsequently establish a more stable conception of himself.

In the teaching of our medical students we also have the advantages of continuity, that is of having them participate in certain exercises and to be engaged in certain assignments over a period of years. The students are directly assigned and are directly responsible for patients under their care with the supervision of the senior staff. All students are taught so that we are not dealing with a self-selected sample of those with special interests. We also have the opportunity to point out the relatedness of matters relevant to our concern with other experiences the student is having in his work in the pre-clinical and clinical sciences. This is not an isolated experience, it is woven intimately into the fabric of human biology with which the student is concerned.
On the other hand, there is little question that there are certain advantages in the teaching of psychiatry to general practitioners as compared with medical students. The practicing physicians are older, more mature, more experienced and have learned through personal living about many aspects of behavior dealt with earlier in their lives at abstract levels. They have the inner motives of therapeutic pressures to help and relieve their patients. They are attempting to learn matters relevant to their needs in the set of being responsible for their patients and earning a living by so doing. What are the possible disadvantages? It is not necessarily true that the older you become the wiser you are. Experience in time may give one opportunities to become wiser, but if a person has certain basic neurotic restrictions at age twenty, further life experience may entrench as well as correct them. The practicing physician may be less flexible, less adaptable, less educable in terms of learning new points of view, new conceptualizations. We have also found that it is not easy to modify the traditional view of medicine common to many practicing physicians in polarizing their dealing with certain matters in terms of scientific precision and treating others with what is called the art or artistic aspects of medicine. There is also the disadvantage of dealing only with a small self-selected and at times self-perpetuating group rather than with a general body of practicing physicians.

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As I indicated earlier, short term courses of a few days duration or weekly lectures over a longer period of time have not been very effective. Obviously, something can be gained, as it is possible to communicate through lectures, through reading and through discussion groups certain substantive matters of fact. For example, I think it possible to discuss matters like the differential diagnosis of dementia, the early signs of delirium, the signs and symptoms of depression, certain signs of impending suicidal acts, the use and abuse of drugs through such mediums. However, if the intent of the teaching is to help the physician become more aware consciously of the therapeutic significance of his relationship to his patient I believe that this can be taught only if there is actual engagement of the student or the doctor with his patient. In this he must be engaged and responsible in responding to the needs of his patient.
When the teaching courses are patterned on the psychoanalytic model in which the teacher sees only the physician alone or groups of physicians without having seen the patients, there is opportunity for the student physician to be helped to learn something of his perceptions, attitudes and feelings towards his patient, and in this way he can be helped considerably to remove some of his more obvious emotional blind spots. I believe that this method, when successful, is by and of itself useful, but I am not convinced that it is sufficient. I believe that it is also necessary for such exercises to point towards conceptualizations of experience from the individual

data that the physician brings to the conference, otherwise the exercise remains fundamentally idiosyncratic, emotional, non-verbal and non-cumulative. When there is little or no opportunity for the teacher to see the patient, that is when the only information available about the patient comes through the student-physician without any cross reference or validation, I believe the value of the exercise is further limited. At times there is a tendency for unchecked and uncritical speculative elaboration of data, limited in quantity and also gained only through the observations of one person. As indicated earlier, I believe that various means should be taken to acquaint general practitioners with certain types of basic information that has been accumulated concerning basic concepts of medical practice. I believe also that these broader conceptualizations are best learned when they are derived directly from the primary data of the physicians' engagement with and responsibility for his patient.

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Let us consider the general physician of tomorrow. Who is he to be? What will be his function? What will he need to become effective? It is generally known that there exist differences in the daily operations of the American general practitioner as compared, for example, with his British brother practitioner. In the past fifteen years in the United States it is stated that specialists have doubled in number while the number of general practitioners has decreased by twenty per cent. To some degree the pediatrician and the internist have assumed the general practitioners' functions at specialist levels. In the United States home calls by the general practitioner in the past thirty years are said to be reduced from about forty per cent to about eight per cent — *Bill of Health (1959) The Economist, London, England.* The American physician rarely works in his own home. Many of them have hospital appointments in one or more hospitals (not commonly the university hospitals) where he retains direct responsibility for his patients. In many American small cities and towns he has been replaced by a small group of doctors, each trained in a different specialty, the group constituting a composite general practitioner. In some experimental American schemes general practice as an independent activity disappears altogether. General medical care becomes one of the functions of a group which also gives specialist care. A truly general practitioner, one who does everything that has to be done for his patient must be rare indeed. I im not sure that I have ever met one, in any part of the world which I have visited.

In America and in Russia many such groups which I mentioned, clinics or polyclinics, are still separate from hospitals. It is quite likely that eventually they will be absorbed into the hospital organization as the hospital is the natural and proper center for specialist work. This may well be the movement in America, namely continuing growth of specialization, group or composite medical practice made up of specialists in a hospital setting.

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As *Fox* has recently pointed out, in Britain with its national health service, such developments are impeded because the independent practitioner is protected under an organization severed from the hospitals but, Fox continues, his independence cannot be preserved indefinitely if his work could evidently be done better in a hospital setting. What is he to do? Is there some important function that he and he alone, not the specialist, or the hospital, or the social case worker can do? Fox believes that this role is not that of general practice but more properly that of the personal or family doctor. Obviously the roles and functions of the independent practitioner, whether one calls him general practitioner or family doctor will inevitably and necessarily vary from nation to nation. These differences will stem from existing political and social trends, from the nature of private and public financial support for health matters in general and from the organizational administrative health patterns established towards prevention, diagnosis, rehabilitation, and therapy. These differences will be influenced, too, by the clarity or confusion of the perceptions and objectives of medical faculties and by the leaders of organized medical bodies. As stated earlier, I believe the physician has and should continue to have a special contribution to make to modern society. I believe that the work of the independent practicing physician will be most effective in the areas of diagnosis, prevention and support, rather than in intensive therapy or in the exhibition of special skills. Just as the practicing physician without additional surgical skills has a fairly clear understanding in surgery of what he can and cannot do, should and should not do, so too I believe, although it is more difficult to delineate, he will one day learn what he can and cannot do and should and should not do in the field of psychological medicine. With Fox and my American colleagues. *Lindemann* and *Caplan,* I believe that the function of the family doctor is and should be fundamentally different from that of the specialist, including the psychiatrist. I do not propose a two-class medical profession with major and minor citizenship privileges. Nor do I believe in the early delineation of specialist versus generalist in the undergraduate medical period. I believe there is sufficient evidence, however, to identify different functions for physicians who are responsible for different tasks and that these must be identified and understood clearly. Certainly the family physician must be informed sufficiently to be able to identify the early signs of illness and to call upon help from his specialist colleagues in hospitals when and where indicated. But beyond this when he is called into a family to handle symptoms of distress in one or more of its members, he and he alone is in a unique pos-

ition to identify and recognize those aspects of his patients' distress which could endanger or threaten the stability of the family group as a whole.

Caplan reminds us that this responsibility has been clear for years in cases of contagious disease, but we now realize that it applies as well to the social and psychologic effects and results of any illness. We have much to learn about the human family, its strengths and weaknesses and the nature of the bonds between its members. It is generally agreed when the traditional pattern of any family is altered by situational factors, the mental health of its members may be affected. The family physician is one of the key persons who is in contact with people when they are in a state of crisis. It is well known that illness of any type may be a turning point which determines the change in the whole course of a person's existence and that of his family. Less well known is that psychological and social events may contribute significantly to the onset of physical illness (*Greene; Schmale*).

People become emotionally upset during these crisis periods. The symptoms exhibited by them are not necessarily signs of morbidity, that is of psychiatric illness, but may be those of the active struggle in process by someone attempting to adapt. At the end of a few weeks of crisis various solutions may ensue. It is in these periods that a number of us believe the family doctor may play an important part in prevention and support, in helping the person reach towards healthy solutions and avoiding entrenchment and neurotic exploitation of the disruption.

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Are these crises restricted to those of manifest physical illness in the member of a family? I believe not. There are, however, more or less normative crises which occur frequently in the course of family life. It is about these that the family physician can become aware and participate intelligently in their resolution. Let me mention a few which come to mind:

1 the avoidance of unnecessary hospitalization of children, and the need for proper timing of elective surgical intervention in childhood;

2 problems of bereavement, that is of normal and morbid grief following the separation by death, disappearance, divorce of members of the family;

3 the management of isolated instances of sexual indiscretion in traditionally sexually continent and faithful husbands and wives;

4 the management of the shame, anger, guilt and fear of parents of defective, psychotic and crippled children, particularly in facing decisions of institutionalization;

5 maintaining integrity of the family in instances of illness of the mother and the need to become aware of existing community social and health agencies to assist in maintaining family continuity for father and children when mother must go to the hospital;

6 continuing support to the family, one member of which has become psychotic necessitating hospital care;

7 awareness of early delirium in child or adult due to its many determinants, particularly in terms of the over-dosage of drugs;

8 awareness of early dementia and the need to avoid sudden changes in the environment and practices of the aged person;

9 awareness of emotional problems in the responsibility of young married couples to their parents in terms of social relations, housing, finances, discipline of children;

10 changes in the body image with age and the special problems that men and women face in our society at the age of fifty, relating to integrity and examination of their earlier ideals;

11 problems relating to preparation for marriage, early marriage years, sexual adjustments, of moving to new neighborhoods and to new groups;

12 awareness of subtle rescue signals frequently directed to the physician by desperately upset persons contemplating suicide.

Obviously, these matters necessitate not only some understanding of the intra-psychic life of man but also the need to know more about the reality of the family. What is the nature of the modern family? Which events and circumstances strengthen, which weaken its structure and function? Does it not follow, given the family doctor's awareness and understanding of his role and of his being informed and alerted to the changes occurring in the patient and his family, that he may become more effective and deal more appropriately with his patient's problems? Perhaps, in this way, he can avoid the pitfalls of casualness and errors of omission in identifying and treating properly his patient's problems. Perhaps, too, he can avoid the equally distressing errors of commission in prescribing unnecessary drugs, or too many drugs for too long, of unnecessary tests and hospitalization, of unduly prolonging dependence upon him.

In short, I believe the functions and responsibilities of the family doctor to be the following:

a diagnostic and judgmental, in identifying illness and making judgments initially and later as to the course of study and care to be followed;
b preventive, in contributing to those measures which modern medical science has provided to prevent the onset of further development of illness, including awareness of the emotional crises alluded to earlier;

c therapeutic, in first aid, advisory and supportive treatment to the patient and to the patient's family in times of acute illness and in continuing care;

d integrative, in directing the patient to the hospital when necessary, to correlate the contributions of hospital study when such are done for the continuing care of his patient, to call upon relevant agencies in the community for assistance in the care of his patient;

e investigative, in pursuing clinical and epidemiologic studies of the effects of chemical, physical and psychologic agents on the course of his patients' illness; in contributing to a fuller, more realistic knowledge of the impact of illness on the family;

f educational, in informing, clarifying and correcting misinformation on health matters with his patient and the patient's family; in acquainting them with the nature of illness and of proper sources for prevention and treatment. He can also serve as an educational source to the community at large and to the hospital and medical school. He is in a position to add immeasurably to our store of information concerning the nature and course of illness and its impact on family life. In the present day multiple person state of our society he is in a position to provide stability and continuity of care, not only to patients acutely ill but also to those who are chronically sick and who can be cared for properly in their homes.

Finally, how is the physician to become so prepared? In my view, this would depend first on the nature of his undergraduate medical education; second, on the nature of his hospital experience beyond his undergraduate period. Those of us in the university and the hospital have much to learn from the family doctor. How can we learn this? How can this be communicated to our faculties, our medical students, our interns and house officers? In this I believe there will be many variations on the theme, local, sectional, and certainly national.

In the United States, I would predict that certain types of group practice will become more intimately associated with hospitals. Within these groups, or to these groups, will come family doctors for advice, assistance and also to contribute their experience to the group, to the hospital, and thus to our students and faculty. Currently in our country, there are experimental assignments of students to family doctor preceptors and to the continuing health care of families. In terms of the continuing education of the family doctor in the field of psychological medicine, I believe here, too, there will emerge not one but many patterns of teaching and learning. Certainly the psychiatrist of tomorrow, if he is to make an effective contribution to the family doctor, must obtain knowledge and learn methods not known to him at present.

The idea that the psychoanalyst or the psychiatrist is the image or model with whom the family doctor must identify precisely is to me as mistaken as is the idea that the models of the surgeon or the radiologist should be those to emulate exclusively. The psychiatrist must learn the nature of the family doctor's job if he is going to help him. The family doctor's responsibility is to acquaint his medical colleagues with his job. What does he do? What knowledge and tools does he need? How can he be helped by the rest of us?

In the United States, I think the family doctor will become more intimately associated with the staffs of psychiatric units in general hospitals. He will use these means as he uses the same hospital for help with his patients needing surgery or complex hematologic studies. To these units he will send his patients when it is necessary to do so. Here he will be able to continue to see his patient, if not care for him exclusively; here he will arrange for patients to be followed by him or by the clinic staff. Here he may be helped to work out extra-mural social agency assistance when needed. Here, too, he will develop a relationship with preferably one or more of the staff with whom he can meet regularly or call on in times of need, in order that he may share his experiences and perplexities about his patients, and to share his personal distress in dealing with his patients' problems and, last but not least, to educate the psychiatrist in areas of experience hitherto unknown to him.

Finally, the physician is not only a physician but he is also a citizen. A physician is not a greater man than another solely by virtue of his technical competence. He has occasion to learn methods of logical and scientific inquiry. He has an extraordinary opportunity to learn something of the motivation of human behavior and thus of the human mind. Modern medicine invites an opportunity for the development of the capacity for critical perception of the problems which he as a physician and citizen faces. He has a particular responsibility to study thoroughly the problems which medicine faces today so that he can apply his accumulated knowledge and experience wisely to their solution. He cannot do this if he is frightened, angry, or uninformed. Without this application he cannot continue to enjoy and to deserve his previously well-earned tradition of social leadership and responsible citizenship (Romano).

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