

# Mental health inside the primary care ; a different mental health ?

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Il reste que la fonction du médecin consiste à aider le malade à déchiffrer sa demande et à lui trouver des réponses, autant dire qu'il y a tout lieu de chercher à comprendre le désir réel pour amorcer la négociation.

Jean Carpentier, Médical Flipper <sup>(7)</sup>

## Summary

Family medicine is the first level of help for patients facing illness or ill-results of the practice of medicine. Settler, listener, defender, the general practitioner occupies a potent position but an uncomfortable one. It is necessary to understand the highly complicated position of the family doctor in western society before discussing mental health in the field of primary care. The forces and weaknesses of the family doctor's position will be summarized. The various mental health classifications will be tied to their conceptual patterns.

### 1. A new concept does not dismiss the previous one

"It is to take out the evil" : This was the answer given by a mentally borderline patient when asked why he absolutely wanted blood drawn.

The concept of disease evolves with time. This patient sees his problem as would Hippocrates<sup>(15)</sup> himself: his disease is an evil humor to be eliminated. His quest will be answered with the tools of the techno-sciences. The more blood samples are taken, the more skillful the doctor will be in this patient's view. Understanding this patient requires in fact a more global approach, the biopsychosocial one.

Claude Bernard has given medicine a tremendous boost by applying the fundamental laws of physics and chemistry. His positivist vision has profoundly changed our knowledge and our perception of the sick man.

He thus initiated the biomedical trend which permitted so many victories over sickness. On the other hand, this scientific vision is also responsible for the hypertrophy of secondary care.

The emergence of psychoanalysis in General Medicine is mostly due to Balint<sup>(5)</sup>. He showed the way towards self-reflection on the profession, the patient and the therapeutic relationship. He introduced the real life of the patient in the consultation.

Medicine becomes socially legitimate and its description more accurate. From biomedical concept it has graduated to biopsychosocial<sup>(42)</sup> concept. The field of medicine expands to include the entire experience of life. Perceiving the patient as a complex and symbolic being has revolutionized the technique of history taking and curing<sup>(28)</sup>.

General medicine is no longer interested in the individual alone but it will now also take in charge the family or the group surrounding the patient. The systemic approach becomes a working tool particularly useful in mental care<sup>(8)</sup>.

As societies become pluricultural, the GP has to appreciate his patient's complaints in the light of their cultural background. The practice of ethnomedicine becomes essential<sup>(12)</sup>.

So we find ourselves in a highly complex<sup>(32)</sup> and risky situation. Various models<sup>(1)</sup> (essentialist, biomedical and biopsychosocial) coexist in a new interactive relationship with the suffering individual, family or society.

## 2. Specialized Medicine and Family Medicine : an agonist/antagonist couple

Recent overdevelopment of technology and specialized medicine only masks temporarily the fundamental values served by the physician of everyday life and suffering.

Specialized medicine	Family medicine
1. Specialized field. Secondary and tertiary level of care. Highly technological	Primary office and home. Mostly communicational
2. Fragmented knowledge	Global knowledge
3. Biomedical model	Biopsychosocial model
4. Closed history taking Logic of questioning	Circular exploration of complaint
5. Transversal Partial opinion and therapy	Longitudinal Taking in charge and synthesis
6. High prevalence	Low prevalence
7. Hospital care	Community care
8. Mostly curative	Integrated (preventive + curative)
9. Medical coordination	Multidisciplinary coordination
10. Material cost , techniques	Human cost
11. Provider and disease oriented	Patients and problems oriented
12. Clinical research	Operational research

Fig. 1 : Specialized Medicine versus Family Medicine  
(Adapted from M. Roland 1991)<sup>(38)</sup>.

The agonist/antagonist relationship between the two types of medical practice is clearly obvious from this presentation of their different levels of activities. We can therefore expect these two different worlds to use different tools of classification.

While the specialist is mostly transversal and technological, the GP is longitudinal and mostly conversational. By taking the time and talking, the family physician is in a privileged position to unveil the hidden side of symptoms.

The "Suitcase of Symptoms" imagined by Jean Carpentier<sup>(7)</sup>, a GP working in Paris, is a stack of plastic transparencies. Each transparency bears the name of an element on which the symptom is founded : Work, Family, Culture or History, all appear behind the symptom which the patient presents on the surface. This depth of vision shows the human being in all its complexity and it probably explains why the present classifications of mental illnesses are inadequate in General Practice<sup>(20)</sup>.

## 3. Evolution in the nosographic field

Emerging from the Hippocrates' uncertain heritage, the 19th century built its first instrument of classification around the concept of death. The International Classification of Diseases, now in its tenth edition, was born from the classification of the causes of death by Bertillon<sup>(34)</sup>.

The ICD is the favorite tool of biomedical research and specialized medicine. Typically centered on diseases and health care providers, it is the result of elaborate thinking by medical specialists and is utilized only in a static fashion. But from there was derived the first tool specific to Family Practice, the International Classification of Health problems in Primary Care (ICHPPC)

The ICHPPC<sup>(43)</sup> was adapted from the ICD. It was still centered on the health care provider but it recognized for the first time the particular significance of the General Practitioner.

The transition to the biopsychosocial concept took time<sup>(11)</sup>. The main tools for primary care were developed by health care providers.

Whether the classifications are monoaxial somatic as those proposed by Braun<sup>(6)</sup>, or pluriaxial as those by Deliege<sup>(10)</sup>, Jenkins<sup>(20)</sup> or the World Health Organization (WHO-PHC)<sup>(9)</sup>, they do not take into account the interactive dynamics of a medical encounter.

These particular dynamics were finally acknowledged with the apparition of the Reason for encounter Classification (RFE)<sup>(25)</sup>.

This RFE, together with the ICHPPC and the Classification of Procedures and Diagnoses (IC-Process-PC) gave birth to the International Classification of Primary Care (ICPC)<sup>(26,47)</sup>, which was the first attempt to express the global approach so characteristic of Family Practice.

#### 4. The era of information

The concept of information and the advent of computers<sup>(19,31)</sup> have revolutionized the application of these tools of classification. Medical softwares offer vast possibilities for the treatment of information and the refinement of hierarchized nomenclatures such as Read Clinical Codes(RCC)<sup>(37,46)</sup>.

But while specialized medicine develops only very static tools, family medicine is pressed by its brilliant advances and seeks to create tools necessary for a dynamic research<sup>(39)</sup>.

The ICPC is not just a classification. It is a multiaxial tool based on the patient and it offers vast knowledge in primary care<sup>(16)</sup>. Computers allow in-depth study of the concept of episode which is at the center of the ICPC<sup>(35)</sup>.

The following table summarizes the evolution of classifications through time, taking into account the main changes in medical concepts.

Current	Concept	Object	Expression
Essentialist	Hippocratic	inside/outside	The Humors
Scientist	Biomedical	Provider centered	ICD-10 / Braun / ICHPPC
Scientific*	Biopsychosocial	Patient centered	RFE + IprocessPC + ICHPPC-2d CDMI / Jenkins WHO-PHC
Computerized	Information	Health information system	RCC/computer dictionaries
Multiple additive approach **	New clinical method General/Family Medicine	Patient/family and social environment Primary Health care Health Information System	ICPC and its episode based methodology

\* Scientific : involves in our view the whole spectrum of knowledge, including the fields of biomathematics, psychoanalysis and human sciences.

\*\* Multiple additive approach : these concepts are not isolated. They coexist most of the time and form an integral part of the informative system thus generated .

Fig. 2 : Evolution of concepts and classifications in medicine

As time changes, so does the work of the general practitioner.

As the central figure in the delivery of primary care, the GP has become necessarily polyvalent. Besides running his health center and dealing with his personnel<sup>(40)</sup>, he must excel as a clinician, master psychosocial problems, integrate analytical knowledge, understand transcultural attitudes, manage the information given by his patients in a dynamic fashion, promote community health and practice preventive

5. Medicine can be dangerous for your health

Throughout time, cultures and medical customs, the human being is confronted with changes in the very concept of health. This is especially true of mental health. Hellstrom<sup>(14)</sup> has clearly shown the dilemma of the potential patient. By integrating disease and sickness, he describes in the patient four different self-perceptions which are expressed in very distinct ways during the medical visit.

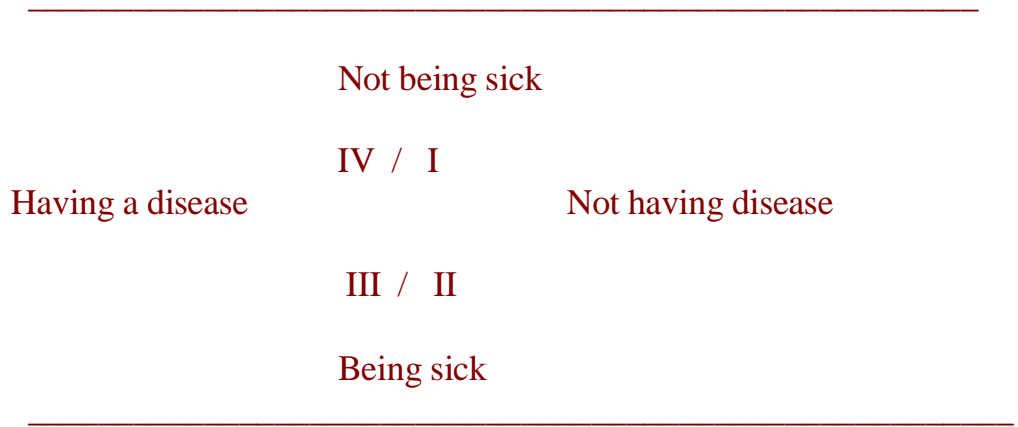


Fig. 3 : Hellstrom O.W. (1994)<sup>(14)</sup> ;  
 "An effort to graphically represent the relationship between a person who is or is not sick and the fact that they have or have not developed or been afflicted with a disease"

From a similar perception one of us deducted some years ago an analogous figure<sup>(19)</sup>. Integrating the physician's knowledge and the patient's conscience, we can determine four possibilities:

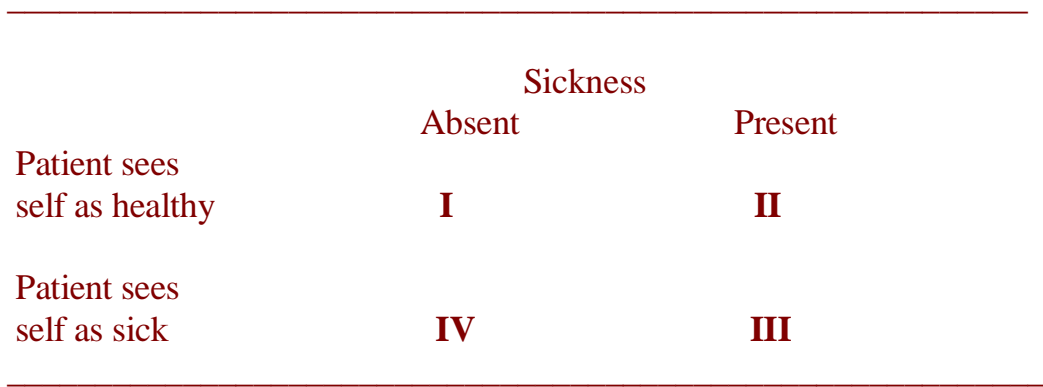


Fig. 4 : Jamouille M. (1986)<sup>(19)</sup>. Four zones of patient/physician encounter.

Those patients who truly belong to group I are not safe from the dangers of medicine. They are exposed to vaccinations or health promotion campaigns. Those in group II who are picked up as positive during a screening test will join group III. Some in group II who are overly sensitive or who are the victims of misconceived preventive medicine will join the hypochondriacs in group IV on whom research will be needed to determine if the disease classifications they fall under are accurate<sup>(33)</sup>. This group IV serves as a testimony of the excessive medicalisation in today's social and mental life. These patients are the victims of the wild overgrowth of medical productivity<sup>(28)</sup>.

## 6. Defining the problems of mental health in primary health care

It is clear therefore that paradigms must be changed if we are to deal with primary health care and especially the mental health of everyday patients.

It is not certain that physicians are willing to cope with the social field. Indeed ethical problems caused by changes in paradigms appear in classifications developed for primary care.

Chapters P (psychological) and Z (social) of the ICPC contain less than 100 items, while the 'Codes pour un Dossier Médical Informatisé '(CDMI)<sup>(10)</sup> developed at the University of Louvain (Belgium) includes 400 codes for the same chapters. The codification of the CISP is minimalist and reserved. That of the CDMI is interventionist and normalizing.

Medicine based on the subject does not draw a consensus either.

The disease is often thought to be more interesting than the diseased, and the diseased himself is often more interested by a "good" disease than by an inquiry into his relationship with his surroundings. One has the physician that one deserves. It is an illusion to believe that the power / knowledge of the physician will not be preserved.

The fact that a pathological state as depression is expressed by symptoms of wildly varying intensity<sup>(36)</sup> does not facilitate the identification of the problem by the physician<sup>(29)</sup>. This difficulty is made even more acute by the extreme fragility of psychiatric classifications<sup>(3,4)</sup>.

The parceling out of the patient by medical engineering is substituted in primary care by a global overview of complex situations where it is not essential to know if the patient is more depressed than anxious or more anxious than depressed. On the other hand it is imperative to consider the patient as an element of a system<sup>(8)</sup> in which the physician also plays an active part.

Last but not least, carefully listening to someone's words can very often supersede useless classifications.

**He has a pain in his back  
and his leg hurts.  
He's bored at home  
with his sick wife  
and he drinks.**

Fig. 5 : Excerpt from Chronicle of a Consultation<sup>(18)</sup>

Can this abstract of a visit by one of our patients in 1986 be classified under any codification system? What seems important in this contact between two human beings is that one wants to be heard by the other. The procedure itself suggests the diagnosis.

A new clinical method<sup>(30)</sup> based on the human being will express the complexity of this being. The patient can not just be classified, he has to be listened to. It is the physician's activity that needs classification, it is his activity that has to be analyzed for an understanding of the care offered to the patient. The principles guiding Quality Assurance will then come into practice<sup>(1,13,21)</sup>.

## 7. The ICPC, more than a classification

The ICPC seems to have proven its value. With regard to reasons for encounter, it tolerates well reporting variations between physicians and it offers a steady correlation between patient and provider<sup>(22)</sup>.

Its organization in episodes provides a dynamic perspective. With it the evolution of mental health problems can be described as SSP through the uninterrupted taking in charge. Its routine utilization allows detailed analyses and the large amount of data already collected offers a close understanding of the medical practice, especially in the field of mental care<sup>(23,24)</sup>.

The primary care provider carries a heavy psychiatric load<sup>(17)</sup> and he badly needs an appropriate instrument of classification. The ICPC seems to answer this need<sup>(41,48)</sup>. It has been translated in over twenty languages and has been fine tuned by groups of European General Practitioners<sup>(27)</sup>. It has proved useful in evaluating a patient's functional status<sup>(44)</sup>, which is the cornerstone of psychosocial problems.

Its adjustment to primary care does not permit its use in secondary care, except in emergency medicine. However it offers a satisfactory compatibility with the international Classification of Disease- tenth revision (ICD-10)<sup>(45)</sup> which is widely used in the secondary sector.

From the standpoint of mental health, the definitions now being established by WONCA's Committee on Classification will have to take into account the tools that are specific to the secondary sector such as the DSM-III-R<sup>(2)</sup> and to future DSM-IV. Psychiatrists and General Practitioners will have to find a mutual ground of reference and understanding.

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