Editorial

Primary Care in Perspective

In this issue of *The Companion,* we are pleased to reprise a classic approach to the delivery of psychotherapy in a primary care setting—Stuart and Lieberman's *The Fifteen Minute Hour*.[1] Their BATHE method for connecting physicians with the psychosocial contexts of a patient's illness deserves to be widely read and practiced. Clinicians who regularly BATHE their patients will demonstrate empathy for and clinical memory of the very human situations that influence how health and illness are perceived and how coping skills are utilized. This enhances the therapeutic alliance (the ground floor of treatment adherence) and everyone's satisfaction with practice. There is the opportunity to do much more, however.

The further I travel in practice the less I see myself as a "lone ranger" in this ministry of healing. My patients need much more than I can possibly supply in the areas of assessment, early intervention, education, and treatment. Brief psychodynamic therapies are essential for the aforementioned reasons, but there will always be wounds that need more than I can give.

One cannot have practiced very long without understanding that most of the complaints brought to us have their origin in the psychosomatic realm. In many ways, mental health *is* health. However, my toolbox (and my time) is limited, and when faced with clinical situations for which I have no tools or the wrong tools, patients predictably get too much of one and not enough of the other. As the old saying goes, "To a hammer, everything looks like a nail." Wouldn't it be nice to practice in a setting where patients with psychosomatic problems or acute and chronic stressors could immediately be involved in interventions that fit the problem?

There is a growing movement that advocates the integration of behavioral health services and general medical services into a seamless delivery of focused attention on the conditions that actually present in our offices. Integrated delivery does not mean co-location (sharing office space) or simply transplanting the usual suspects and traditional methods. It involves a new approach in which specially trained therapists work alongside clinicians from start to finish during the day. Therapists emphasize brief, substantive visits that educate patients as they cope with grief, marital strife, the demands that chronic illnesses place on them, and so on. Clinicians warmly transfer their patients into this extended, supportive care and are seen as advocates who validate the importance of mental health. Clinicians and therapists may see patients together and can consult freely and frequently. Patients find empathy, destigmatization, and information. Investigations of integrated models have found 20% to 30% offsets in medical cost. More importantly, physicians and patients are more satisfied with health care.

BATHEing our patients will always be in season as we try to foster working therapeutic alliances. Great angst will surely be present as medicine shifts from one style of practice to another. However, change and growth are often necessary and good. For primary care psychiatry, the integration of behavioral and medical health care is one change that deserves a prominent welcome mat.

—J.S.M.

REFERENCE

1. Stuart MR, Lieberman JA. The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician. Westport, Conn: Praeger; 1993