

The psychological care of medical patients

Jonathan Pimm

Psychiatrists and physicians have traditionally been thought of as operating in different domains – one in the mind, the other in the body. Such an approach can be detrimental to patients and frustrating for doctors, since patients receive an inadequate service and treating physicians fail to get to the root of problems caused by psychological mechanisms.

Indications of major changes in practice emerged at this conference of physicians and psychiatrists, which launched a joint report entitled *The psychological care of medical patients: a practical guide*.

As Dr Mike Shooter, President of the Royal College of Psychiatrists, said, 'Patients do not see themselves in the context of their different problems – they think of themselves as a whole'. Yet the trend to consider patients' problems only in terms of symptoms and diagnoses rather than assessing the individual as a whole has contributed to the divergence of psychiatry and general medicine.

In an effort to illustrate and bridge that gap between the body and mind schools of clinical practice, psychiatrist Professor Simon Wessely offered a physical explanation of so-called 'medically unexplained symptoms' and physician Professor Lynne Turner-Stokes offered a psychological one. Professor Wessely's example was a patient suffering from chest pains with no clear-cut pathology. Such patients are best understood as interpreting normal post-exercise muscular pain in a 'catastrophic' fashion. They 'treat themselves' by diminishing their physical activities, but to such an extent that even normal activities produce further muscular pain. They are then trapped in a vicious circle from which they find it difficult to escape.

Professor Turner-Stokes highlighted patients' childhood experiences and patients' history of previous contacts with the medical profession as important psychological factors to bear in mind when seeking a cause for medically unexplained symptoms. She also stressed the need to look for any 'secondary gain' (a benefit to the patient derived from adopting a sick role). Keys to success in treating such patients include, first, the need to recognise and contain the condition, second, a position that does not expect miracles, and third an acceptance of the symptomatology and the disability. Also, rehabilitation has to be under patients' control; they will not have rehabilitation forced upon them.

The often controversial issue of informing patients

about the diagnosis of medically unexplained symptoms saw the physician and the psychiatrist singing from the same song sheet. Both stressed the importance of avoiding saying, 'There is nothing wrong with you'. Doctors need to become familiar and competent at dealing with patients suffering from medically unexplained symptoms since it has been found that up to 40% of consultations with GPs have a psychological basis. Unfortunately, however, the current teaching of doctors is heavily weighted in favour of the biomedical model with a clear pathological cause. Medical students should be taught a more integrated approach.

Communication between doctors and patients and doctors and their colleagues was emphasised as being a key to future progress. Dealing with a man lying in bed on a cancer ward, a physician begins his conversation with the perfectly appropriate question: 'How have you been since I last saw you?' Certainly, a good opening statement aimed at encouraging the patient to voice any ongoing concerns or worries. And indeed it brought the desired response, when the man asked, 'Am I going to die, doctor?' However, the doctor, unable to deal with such a direct retort, adopted the

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Conference programme

■ Psychological response to illness

Professor Else Guthrie, University of Manchester

■ Managing the difficult consultation

Professor Peter Maguire, CRUK Psychological Medicine Group, Manchester

■ Detecting depression

Professor Amanda Ramirez, Guys', King's and St Thomas' School of Medicine, London

■ Treating depression: when and how

Dr Geoffrey Lloyd, Royal Free Hampstead NHS Trust

■ Medically unexplained symptoms: explaining the unexplainable – a rehabilitation physician's perspective

Professor Lynne Turner-Stokes, King's College London

■ Medically unexplained symptoms: explaining the unexplainable – a psychiatrist's perspective

Professor Simon Wessely, King's College London

■ Managing patients with alcohol problems in the general hospital

Professor Francis Creed, University of Manchester

■ Incapacity and treatment refusal

Dr Eleanor Feldman, John Radcliffe Hospital, Oxford

well-used strategy of 'blocking' and replied simply, 'How's your breathing been...?' Several other examples of how not to manage difficult consultations enlivened the proceedings.

Quite simple communication skills can be very effective in detecting psychiatric disease in physically ill patients. Simply asking a patient, 'Are you depressed most of the time?' and further enquiring about mood will detect a large proportion of morbidity.

It is interesting to note that patients' actual illness is not the key to how they will respond to their illness. Rather, it is the amount of stress associated with the illness, the experience of being hospitalised and the types of coping strategies adopted by patients that will influence their response to the illness. However, most people, given time, develop their own ways to manage illness; and it is important to differentiate a normal response to a distressing physical illness from an abnormal response which may require psychiatric treatment.

The key for detecting such illness is a multi-level service which gives all members of a team the necessary skills to recognise a

problem about which they could then speak to a specific member of the team. Further, the designated team member must know when and how to refer patients to specialist services from psychologists or psychiatrists. Unfortunately, the availability of counselling services within the NHS is severely limited, yet psychological problems in patients with physical diseases are eminently treatable, using either medication or psychotherapy.

In summary, the conference laid the foundations for psychiatrists and physicians to work together more extensively in the future in an attempt to appreciate the psychological and physical aspects of patients. Further, it proved that clear lines of communication are important in bringing about such changes.

Recent advances in predicting the response to clinical rehabilitation

Alison Burbidge

Is it possible to predict who will benefit from rehabilitation?

Several factors help to predict the response to rehabilitation; for example severity of disease, an individual's ability to understand and learn, and his/her belief in the treatment's efficacy. However, few studies have sought to separate the effects of medical treatment and spontaneous recovery from the effects of rehabilitation. Therefore, in measuring response to rehabilitation it is essential to identify objectives and outcomes that genuinely reflect the process of rehabilitation, which is essentially to solve problems and teach skills rather than to make 'normal'.

Can specialist rehabilitation teams reliably predict their patients' outcomes?

An early prediction process used in a specialist rehabilitation unit for Service personnel suffering from traumatic brain injury (TBI) was remarkably accurate. After a two-week assessment, patients were assigned a rating on five hierarchical scales: vocation, independent living, communication, leisure and hobbies, and awareness and acceptance. These ratings

were then used to set short-term, long-term and outcome goals. The accuracy of predictions made over one year for the vocational and independence scales was 89% and 75% respectively at three months, and 88% and 74% at 12 months. Thus, general vocational and independence status of brain-injured adults could be accurately predicted two weeks after admission.

Accurate prediction required a skilled multidisciplinary team able to recognise prognostic indicators after a comprehensive initial assessment, and to act upon them with someone to coordinate and lead the process. Reasons for inaccuracy included inadequate information on the severity of injury and failure to detect pre-existing emotional difficulties. Lack of improvement between three and 12 months was often due to inadequate community input and lack of opportunity to change.

Positive and negative predictors of response to rehabilitation

Stroke

The relationship between predictive factors (for example, incontinence or paresis) and outcome (for

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