



"Caring For Patients," by Allen Barbour, MD

A Book Review

"Caring For Patients" by Stanford physician Allen Barbour is an important medical book which addresses issues critical to routine medical practice. An uncommon treatise like this could shape the future of one's medical practice as well as the economics of medical care.

Barbour points out that experienced physicians have been trained to diagnose and treat organic disease although most patients seen in any given medical practice have illness caused by personal distress; many patients who come for help are not well accommodated by the biomedical system of diagnosis and treatment. Many diagnoses are deferred indefinitely, and evaluations are commonly extended and futile. A major component of the soaring costs of modern medical care, "high-tech" diagnostic procedures are often ordered when seeking a disease-based explanation for what are really unrecognized functional disorders. In the organ-based specialties, physicians rule out conditions instead of ruling them in, leading to both dilution of responsibility and collusive physician anonymity. The author recalls Eugene Stead's famous comment: "What this patient needs is a Doctor."

Barbour considers several common functional disorders worth listing because they are frequently misrecognized and misrepresented: anxiety, depression, fatigue, weakness, obesity, anorexia, impotence or anhedonia, disturbed sleep, headache, backache, constipation, diarrhea, indigestion, bloating, abdominal pain, musculoskeletal chest pain, and chronic pelvic pain. Although 87% of all emotionally based illnesses manifest as "medical" symptoms, functional symptoms are evaluated for organic disease as though the opposite were true.

Emotional expressions are inherently physical: they have evolved to unify mind and body in a common purpose, and great overlap can be seen between functional and organic expression. In organic disease, biologic determinants predominate; however, long-term psychosocial aspects of human life are the factors which actually determine morbidity and mortality. Indeed, much disease results from attempts to control the forces which initially led to illness. Thus, for example, endocarditis may result from intravenously administered drugs used to feel better by someone who feels profoundly bad. *That* is the core problem. Barbour quotes Stead's comment: "If one doesn't know what is actually going on, then one doesn't really know how to handle it."

Commonly, each possible organic disease is ruled out before the physician considers functional disorder as the diagnosis. This practice is improper and

destructive: both varieties of diagnosis should be considered from the outset. Psychosomatic disorders can be detected only as a result of positive diagnosis and not by default. Personal situations which correlate with increased morbidity and mortality from physical disease include degree of parental deprivation, quality of childhood experience, and quality of social support. The author references a 7000 person study in which middle-aged men with the fewest interpersonal connections had three times the mortality rate of a matching group with the most interpersonal connections.

Feelings are either expressed or suppressed; they cannot be obliterated through containment. If suppressed, they emerge either as physical symptoms or as unfocused emotional expression such as anxiety, depression, or other psychiatric syndromes. Because most emotionally distressed persons are only dimly aware of the source of their distress or are overwhelmed by it, their tension mounts until physical symptoms result or until anxiety or depression increase to a level triggering a psychiatric diagnosis. Indeed, unconscious suppression of emotions and failure to understand their link to symptoms is the rule in medicine: by focusing on symptoms instead of their underlying personal problems, people define themselves as sick and thus seek relief from doctors. Complaints about symptoms trigger the medical model.

In general, pain is usually and incorrectly thought to be primarily caused by organic disease. Barbour studied 400 consecutive Stanford University Medical Center outpatients and found that in 174 of them, pain was the dominant symptom. However, when these 174 patients were thoroughly evaluated, the pain was found to be due to psychophysiologic reaction in 28%, somatoform disorder in 39%, or organic disease in 33%.

As an example of the diverse origin of pain, the three most common causes of recurrent anterior chest pain are cardiac, esophageal, and psychogenic. Unfortunately, exclusion of a cardiac cause typically discourages further diagnostic or therapeutic steps from being taken. This practice is unsatisfactory from the patient's viewpoint because lack of diagnosis equates with lack of knowledge: if the doctor doesn't know what *is* going on (i.e., doesn't confidently apply a diagnostic term), why should the patient trust the doctor's opinion of what *is not* going on? This failure to resolve the problem is expensive, partly because it virtually assures future visits to find an answer. In a large study of patients in a headache clinic, for example, the dominant concern for 77% was explana-

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tion of their illness, not pain relief. Barbour elsewhere describes chronic backache as “an illness in search of a disease.” In this regard, Barbour points out that CAT scans showed herniated nucleus pulposus in 10% of asymptomatic volunteers aged <40 years; 27% of asymptomatic volunteers aged ≥40 years, had a herniation. Chapter 13 includes interesting, scholarly, well-referenced discussions of fibromyalgia, chronic fatigue syndrome, pelvic pain, irritable bowel syndrome, chronic abdominal pain, and various types of headache.

Because the biologic focus is currently so strong, depression has come to be viewed as a disease instead of a response to problems of the human condition. According to Barbour, the biology of depression is the result—not the cause—of feeling depressed. Genetic factors in major depression act not by initiating, but by accentuating intensity of the depressive response. Tricyclic antidepressants are not particularly specific: their effects occur at both ends of the anxiety-depression spectrum. Of little use in mild depression, they are often effective for reversing the biologic dysfunction of more advanced depression. In situations where antidepressants are not effective or are refused, physicians must contribute more time, energy, and personal commitment than most are willing to give. Sufficient time does exist, given the large amounts of time typically ultimately spent prescribing for symptoms one at a time instead of exploring central issues. (This phenomenon is easily observed from patient records.)

Barbour points out that in personal illness, outcome is determined by the physician’s concept of care, i.e., whether care is limited to “ruling out” a particular condition or whether it expresses a more general concern for clinical judgment, helping, and healing. Unfortu-

nately, efforts to understand the patient as a person are most often relegated to psychiatry, a field which itself seems to have abdicated that goal. This problem is compounded by patients who do not consider personal growth to be their responsibility.

Ultimately, how illness is explained to a patient is a pivotal issue determining subsequent events. In psychosomatic illness, it is always helpful to explain that the illness is a common response to distress and that the illness fortunately does not result from disease. Naming the illness is critical; an illness without a named diagnosis will not attract an adequate response from the patient. A useful explanation that the severity of stress-induced illness is often greater in irritable bowel syndrome than in cancer, that the pain of fibromyalgia typically is worse than in rheumatoid arthritis. Saying only that “nothing was found so it must be stress-related” is the mark of the therapeutically destitute and is doomed to failure because it fails to fully acknowledge that something is wrong. The crowning achievement for any clinician is to make the correct diagnosis and, with the patient, to reach an understanding of the underlying problem.

In selecting and abstracting some of Allen Barbour’s words and ideas, I hope that I have done justice to “*Caring For Patients*.” The entire book is highly readable, eruditely written, and meticulously referenced. This uncommon triad of qualities, combined with the author’s extensive clinical experience, creates a work of great merit such as comes along once in a decade or longer. Although Dr. Barbour died just before its publication, his book carries the contemporary banner for ideas developed by George Engel, Richard Magraw, Michael Balint, and Walter Alvarez in their important, earlier books about the nature of a physician’s work. ♦

“Life is full of insurmountable opportunities.”

Pogo