

Editorials

The chronic somatizer and the Government White Paper

'Doctor-shopping' was once seen, by doctors, as a disreputable activity to be curbed for the sake of the patient's health. The bargain-basement rhetoric of the White Paper on the future NHS makes no compromise with such paternalism. As 'extended patient choice' and 'the best value for money' proclaim the shift of power to the consumer, it looks like sour grapes for doctors to warn of the hazards of easier access to specialists.

Rapid access to diagnostic facilities and treatments in the NHS is unquestionably a good thing. The prospect of extra efficiency is reassuring to healthy people who anticipate becoming ill. But it is less clear how services for the chronically ill and disabled will be organized in the 'new NHS', or what the invisible hand of the market will deal out for these numerous yet almost invisible patients.

It is estimated that two-thirds of patients visiting a GP have no serious disease, and that the decision to consult is rarely the consequence of significant organic pathology². Yet many of these consultations are for symptoms which patients attribute to organic causes, but which doctors explain in psychological or social terms. This process of medical help-seeking has been called 'somatization', one definition of which is the 'expression of distress in the idiom of bodily complaints'^{3,4}. In many cases psychiatric disorder or a psychosocial source of distress can be identified and dealt with. This is particularly true of the acute presentations that account for a third of GP consultations⁵. There is, however, a group of patients well known to general practitioners and specialists who are chronically ill with multiple unexplained physical complaints, and who are not amenable to reassurance. These patients have been labelled hypochondriacs, hysterics, 'crocks', 'heart-sink' patients, 'medical care abusers' and less pejoratively, patients with 'abnormal illness behaviour' or 'somatization disorder'. The operational definition⁶ of this last term has been used for research into the prevalence, course and cost of chronic somatization in the United States.

To be a case of somatization disorder by the American Psychiatric Association's DSM III-R criteria⁶, a patient must have several years' history of multiple and recurrent somatic complaints for which no physical cause can be found and which lead the patient to see a doctor, alter life-style and/or take medication. Onset before 30 years, and at least 13 separate symptoms must have occurred before the diagnosis is made.

We have detected many such cases in the outpatient clinics of our own hospital, but there are few prevalence data on this disorder in the UK. In the United States the condition is 20 times more common in women than men, and recent data suggest a

community prevalence of 0.67%⁷. In the only British study the prevalence was 0.2% in women aged 16-25 years⁸; and this lower figure was probably a consequence of the young age of the sample. The British researchers found most help-seekers fell just short of satisfying the American diagnostic criteria.

The US prevalence may reflect the greater availability of, and faith in, high-technology diagnostic facilities and the easier access that patients have to the doctors who use them. Specialists are mainly concerned with detecting/excluding disease of the system that they specialize in, rather than a global appraisal of the patient's ill health.

We are studying the histories of 25 patients referred from specialist clinics with somatization disorder. After reading hundreds of clinic letters it is difficult not to conclude that there is a large iatrogenic component to this disorder. This seems related to both the doctor's adherence to a narrow biomedical model of illness causation and a readiness to comply with the patient's demands for further tests, despite any number of previous fruitless investigations.

Even when emotional disturbance is apparent, the specialist will still often order an investigation to 'exclude' a physical disease. This collusion between doctor and patient can involve a suspension of professional judgement that results from the powerful emotional responses that these patients evoke in doctors. Responses include guilt for failing to 'help' the patient; fear that the patient will make a formal complaint; and anger at the patient who recognizes no limit to his or her entitlement. To avoid a painful, embarrassing and time-consuming confrontation the doctor may decide to pursue further organic possibilities. Further negative investigations or treatment failures may then lead to another specialist referral and a continued avoidance of patient's emotional problems.

An emphasis on diagnostic technology is an inherent part of a model of disease that is mainly concerned with detecting and quantifying physicochemical data on a patient. Such data are usually acquired without any balancing of social or psychological information. The model of illness implicit in the White Paper is this biomedical prototype. This is apparent in the financial rewards offered to hospitals that choose to become self-governing and sell specialist services in a competitive health care market. The Government's medical model is embedded in an economic model. 'Self-governing hospitals will earn their revenue from the services they perform . . . a hospital which is good at its job and attracts increasing numbers of patients will see its income rise'¹. The imperative is to develop marketable, quantifiable services that make a profit for the hospital (as well as the bio-technology industry).

In the government's medical model, ill-health is reduced to a consumer need for such diagnostic and treatment services. This caricature is identical with the chronic somatizer's view of illness.

The patient's access to specialist care is largely regulated by the GP who negotiates this with the patient. This 'gate-keeper' function of the GP may contribute to this country's lower prevalence of



somatization disorder. Once patients are in specialist care, many are reluctant to return to their GP without a physical diagnosis. We have noticed that rounds of specialist referrals often follow a change of GP. Such changes often occur with these patients and are initiated by both patient and doctor. While budget-holding by GPs will increase the incentive not to refer these patients, other changes proposed in the White Paper are likely to lower the GPs threshold for tolerating and containing their complaints. The optimum management of these patients requires time, patience and listening skills⁹, but as Morrell¹⁰ has pointed out, doctors will have an appreciable disincentive to provide this type of care when 60% of their pay is derived from the number of patients on their lists. Combined with changes that will 'make it easier to choose and change doctor'¹, an important check in the process of somatization may be eroded.

By endorsing a more American style of health care delivery and embodying a naive and oversimplified model of ill-health, the changes proposed by the White Paper may bring us closer to the American prevalence rate for somatization disorder. While the aetiology of chronic somatization is poorly understood, somatization disorder cannot occur without medical complicity. It is likely that the type of health care system influences the prevalence of somatization disorder.

American studies reveal that the cost of health care for somatization disorder per capita was \$4700 per year in 1980, ie nine times greater than that for the average person¹¹. Once such patients have embarked on a career in specialist care, their doctors often seem powerless to stop the process. Patients, in turn, seem remarkably adept at eliciting further referrals and investigations. In our series, patients have been on this 'merry-go-round' for an average of 32 years. Many have involved non-medical agencies such as local authority and rehabilitation services, which adds further cost to their care. One of our patients had involved 20 separate helping agencies before she was referred for a psychiatric opinion. Another was investigated at 10 London hospitals during a 5-year period during which she changed general practitioner approximately every 6 months. Her hospital notes revealed that the specialists involved in her case knew little of each other's involvement.

The new self-governing hospitals will be encouraged to compete for their revenue by offering better services than their neighbours. Obviously, the more expensive the service and the more it can be sold, the higher the revenue. The envisaged consequence is further specialization with hospitals selling each other's services. In terms of utilization of hospital resources this may be a recipe for efficiency. In terms of somatization it is a recipe for disaster.

The type of health system envisaged in the White Paper may not only be of dubious value to many patients, it is economically suspect. For while the White Paper describes incentives to 'attract' patients to services, once a patient is in specialist care there appears to be no disincentive for requesting more tests and physical treatments. Quite the reverse: as the majority of patients with somatization disorder are labelled with spurious physical diagnoses, investigating them will improve 'performance indicators'

and attract more revenue. Talking with patients and helping them to see their pains in another way would be unprofitable. Even if the psychosocial origin of these non-organic illnesses were acknowledged, how would the 'efficiency' of their management be assessed? By the number of services not performed? By the decreased demand for services? By consumer dissatisfaction after being denied a further test?

There is a moral ambiguity surrounding the chronic somatizer's status as a patient. The desire to adopt the sick role often evokes indignation in medical personnel. Many conclude that there is 'nothing wrong' with the patient or that they are not 'really' sick because their symptoms cannot be explained in physical terms. Yet chronic somatizers suffer and often become entrenched invalids. Most of our sample are receiving benefits, often multiple. These are usually granted on the strength of spurious physical diagnoses acquired at an early stage in the history of the disorder.

Somatization disorder has recently been acknowledged as a public health problem in the United States, a problem that health care maintenance organizations claim can bankrupt them³. Yet the amount of research funding it attracts is meagre. One reason for this is that psychiatrists are largely unaware of the problem. Most have had little experience of working in a general hospital during their training. There has been virtually no attempt by psychiatrists to treat or manage chronic somatization even though most patients with somatization disorder pass through a department of psychiatry on their rounds of the various clinics. When this happens, any psychiatric diagnosis may be made, but most frequently it is anxiety or depression for which psychotropic drugs are prescribed. Our own data suggest that this type of intervention has no effect on patients' help-seeking behaviour or the number of investigations they undergo. Indeed, attending a psychiatric clinic for treatment of a 'mood disorder' seems to reduce the psychosocial dimension to the extent that it becomes the psychological analogue of the gallbladder or the menstrual problem that other specialists are attending to concurrently. For most chronic somatizers psychiatry is simply another service to consume and many psychiatrists complain that they are ill-equipped to work with these patients. Indeed, specific medical or psychiatric treatments generally have little to offer these patients. Rather, the most crucial aspect of care is 'good doctoring' by professionals who listen, get to know the patient, identify their major problems and provide appropriate support^{12,13}. Recent American work suggests that liaison between interested psychiatrists and physicians can lead to effective intervention¹⁴. It may be more profitable in this country to study intervention at the primary care level, and there is an urgent need for more British-based research in this no-man's land between psychiatry and the rest of medicine.

The White Paper is based on an explanatory model of illness that excludes psychosocial factors. Its proposals, regardless of their economic sense, do not reflect medical realities. There is wide concern that the elderly, chronically ill and handicapped may suffer if the White Paper proposals are introduced. But, in addition to this potential for neglect, we are suggesting that there is an insidious risk to a group of patients whose existence is itself neglected.

Acknowledgments

We thank Professor R H Cawley, Dr Stephanie May and Dr Jane Dammers for their helpful comments.

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Responses to illness - implications for the clinician

Yudkin¹ was amongst the first to draw attention to the observation that patients rarely consult their doctors simply because they have a disease, or even merely because they have symptoms. In his series of 'Six children with coughs' maternal anxiety about asthma or tuberculosis had prompted consultations for two of the children, pressure from her mother-in-law had led one mother to consult, another mother was anxious about her child's eating habits, and two were hoping to enlist the doctor's aid in arranging a convalescent holiday or in keeping the child from school. All of the children were attending a paediatric outpatient clinic, but similar reasons for consulting may be identified during any general practitioner's surgery.

In 1954 Koos² reported a massive study of ideas about health and of behaviour during illness in over 500 families. Each family was interviewed on 16 occasions over a 4-year period. He showed that individuals' consulting and illness-related behaviours are a product of their opinions and attitudes, or health beliefs, and that these vary between different social groups.

A number of subsequent studies have confirmed Koos's findings. For example, Robinson³ studied 20 families in South Wales. Each family was visited and interviewed several times, and each wife/mother filled out a health diary for the whole family over a 4-week period. Illness behaviour in these families appeared to represent the outcome of balancing the short-term and long-term, physiological and social gains and costs perceived for each action or non-action. Thus, illness behaviour was informed by health beliefs, and was rational in the light of these. It follows that illness

behaviour which appears irrational to a doctor is the result of incongruities between the doctor's professional beliefs and the lay beliefs of his or her patient.

What is the origin of lay health beliefs? Ultimately they must be imbedded in the individual's world view, which is a synthesis of ideas learned from others and of the individual's own experiences. During the 10th century, when elves still lived in men's thoughts, the Anglo-Saxon physician Bald described elf-shot as a cause of disease. More recently, in an American study of health beliefs, a boy with eczema explained that his 'skin itched because of allergies which caused a build-up of chemicals and pollens under the surface of [his] skin until [he] scratched them away'⁴. The child is clearly attempting to understand his experiences in the light of the beliefs that he has learned from others, including his doctors.

Less anecdotally, Blaxter⁵ interviewed 46 women in Aberdeen concerning their attitudes and beliefs about health and sickness. She found sophisticated models of causality, clearly rooted in the women's experiences even if at variance with the current professional medical model. Blaxter concluded that 'These women's beliefs about cause could be demonstrated to have a direct effect on their help-seeking behaviour . . . there are many examples of the women worrying over symptoms, consulting again and again, because (although they had been given a diagnosis) they had not been given a cause or at least one which they found acceptable.' This clearly illustrates the importance to the clinician of understanding his or her patient's health beliefs and anxieties before attempting to modify these by, for example, offering a diagnosis.

Along with beliefs and anxieties about his or her illness, a patient comes to the consultation with certain expectations of the doctor. These too are rooted in the patient's beliefs and previous experiences, particularly previous experiences of