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•Editorial•

Comorbidity of mental and physical diseases: a main challenge for medicine of the 21st century

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Over the past two decades the prevalence of comorbid mental and physical diseases has increased dramatically, reaching epidemic proportions in many countries. In persons over the age of sixty the simultaneous presence of two or more diseases has become the rule rather than an exception. Comorbidity is also increasing rapidly at younger ages where the negative consequences of comorbid conditions are as numerous and as troublesome as those that occur at a higher age. There is every reason to believe that this increasing trend in the proportion of individuals who have comorbid conditions will continue in the years to come. This prediction is based on several facts: first, the successes of medicine in prolonging life without curing disease makes it easier to simultaneously contract two or more illnesses; second, demographic changes (with an increased proportion of the population reaching a higher age) increase the time individuals are at risk for a number of late-onset diseases; third, the epidemic spread of unhealthy life styles increases the likelihood of occurrence of several diseases which tend to appear together – such as cardiovascular diseases and diabetes; and fourth, it is possible that deterioration of the environment will lead to a higher intake of pollutants and abnormalities in the immunological system of humans and, thus, facilitate the occurrence of allergic and other diseases.

Comorbidity does not mean the simple addition of two diseases that independently follow their usual trajectories. The simultaneous presence of two or more diseases will worsen the prognosis of all the diseases that are present, lead to an increasing number (and severity) of complications, and make the treatment of all of them more difficult and, possibly, less efficacious. A series of reviews published in recent years provides ample confirmation of these findings.[1-7]

What is worse is that one of the comorbid diseases is often overlooked. This is particularly true for mental illnesses which are frequently comorbid with physical illnesses. Non-psychiatric specialists and general practitioners are usually focused on the illness about which they know a great deal and which they wish to treat, often missing or underestimating the importance of mental disorders that might also be present. For them the distinction of the distress that often accompanies serious physical illness (e.g. cancer) and a mental disorder (such as depression) is rarely clear, so they proceed with single-disease treatments in the belief that the psychological symptoms associated with the physical illness will disappear once the physical illness is treated. Specialists in disciplines other than psychiatry and general practitioners avoid making a diagnosis of mental illness – partly because of their uncertainty about the diagnosis and treatment of psychiatric disorders and partly because they would like to avoid the perceived stigmatization of their patients that occurs when they are labeled as 'mentally ill'.

Psychiatrists are no better than other specialists at identifying comorbid conditions. They often deal with the mental illness they have extensive experience with and miss or undertreat a comorbid physical illness – often skipping a medical examination which might tell them about the presence of another illness. The admission of psychiatrists' reluctance to deal with physical illnesses in patients whom they treat for a mental illness is most clearly demonstrated in the creation of a special subdiscipline–liaison psychiatry. No other medical discipline has a similar subspecialty; there is no liaison orthopedics or liaison cardiology because it is expected that anyone specialized in orthopedics will care for their patients' cardiac problems and that anyone specialized in cardiology will deal with their patients' orthopedic problems. One can hope that in the future all psychiatrists will acquire sufficient knowledge to diagnose and treat (or refer) non-psychiatric diseases and that the discipline of liaison psychiatry will, therefore, become unnecessary. But we are far from this goal. For the time being we

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can admire psychiatrists who are able to provide care to people who have a physical as well as a mental disorder and regret that many cannot or do not wish to do so.

Another discipline that deserves a comment is that of psychosomatics. Many years ago an expert committee convened by the World Health Organization recommended that the words psychosomatic medicine and psychosomatic illness should be avoided because when these terms are used they imply most diseases (i.e., those that are not psychosomatic) are either purely physical or purely psychological. This recommendation was not widely followed so there are now many specialists in psychosomatic medicine and several professional organizations that promote the discipline of psychosomatic medicine focusing on diseases with physical symptoms in which the role of psychological factors is particularly prominent. Now that the term is firmly established it is important that specialists in psychosomatic medicine, psychiatrists and enlightened clinicians in other fields take it as their goal to promote the notion that all diseases have psychological as well as somatic components and that the treatment of all diseases requires that equal attention be given to both of these components.

Appropriate management of comorbidity – at the individual and at the public health level – will require a significant reorientation of medical education and a reorganization of health services. General practitioners can be trained to identify and treat patients with comorbid conditions, but specialists in all disciplines must also assume some of the responsibility for dealing with the issue of comorbidity in the patients whom they treat. Health services will have to be adjusted to the fact that most of the people who come to seek help are likely to suffer from more than one illness. Researchers will have to give more attention to the commonalities in the pathogenesis of mental and physical disorders and to the development and assessment of strategies for the treatment of comorbid conditions. As a first step, all of us will have to accept the fact that comorbidity of various diseases and in particular the simultaneous occurrence of mental and physical disorders is the rule rather than an exception and that we have to approach all our patients with this in mind. We must also make efforts to convince decision makers, educators, clinicians, and community members that comorbidity is one of the most urgent challenges to the quality of health care in the early decades of the twenty first century that must be recognized and dealt with without delay.

Conflict of interest

The author reports no conflict of interest.

References

1. Leucht S, Burkard T, Henderson JH, Maj M, Sartorius N. Physical Illness and Schizophrenia. A Review of the Evidence. Cambridge, UK: Cambridge University Press; 2007.
2. Katon W, Maj M, Sartorius N. Depression and Diabetes. Chichester, UK: Wiley-Blackwell; 2010.
3. Glassman A, Maj M, Sartorius N. Depression and Heart Disease. Chichester, UK: Wiley-Blackwell; 2010.
4. O'Hara J, McCarthy J, Bouras N. Intellectual Disability and Ill Health: A Review of the Evidence. Cambridge, UK: Cambridge University Press; 2010.
5. Gordon AJ. Physical Illness and Drugs of Abuse: A Review of the Evidence. Cambridge, UK: Cambridge University Press; 2010.
6. Kissane DW, Maj M, Sartorius N. Depression and Cancer. Chichester, UK: Wiley-Blackwell; 2011.
7. Kurrle S, Brodaty H, Hogarth R. Physical Comorbidities of Dementia. Cambridge, UK: Cambridge University Press; 2012.

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