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Expert opinion

The wrong model

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Government plans for the future of the NHS have been criticised on many grounds, but rather little has been said about their fundamental misconception of the nature of much medical practice. In the acute medico-surgical model of the White Paper, the patient seeks help for physical symptoms, undergoes diagnostic tests, and is satisfied with a drug prescription or a surgical repair or excision. The relationship between patient and clinic is exactly like that between automobile and garage-service station. The fact that patients are human, wilful, psychologically complex is ignored. Yet in the medicine of real life, and particularly in psychiatry, the behaviour of the individual in his social setting, and his own ideas about his biology, play an enormous part. They decide whether he will see a doctor at all, and what treatment he will accept. Ignoring them predisposes to waste of resources, failure to solve soluble problems, continuing illness, community concern.

Many patients come to the psychiatrist (or the GP) at least partly to satisfy some relative, neighbour, teacher, social worker or policeman – who must therefore also be given satisfaction by the clinical management – and not for their own symptom relief. So patient–consumer satisfaction is not a full test of good treatment.

Symptoms are not neutral perceptions but also expressions of anxieties or tokens to engage the doctor's concern, even though they have a physical basis. A drug prescription, even when backed by the magic of X-ray or urine and blood test, is not often sufficient by itself for cure. The doctor must (and does willy-nilly) offer some human responses too: listening, encouraging, taking on the anxieties. Sometimes the interplay of the relationship is all that is needed, and the physics and biochemistry can be left out. Allowing talking time, especially in chronic conditions, can prevent deterioration and hospitalisation; but the government's idea of value for money is brief interviews and rapid turnover.

One kind of patient we all meet sooner or later is the woman who has been many times to her GP with complaints of bodily pains, itching skin, etc., which never seem curable. He refers her to one specialist after another, orthopaedic, gynaecological, endocrinological, dermatological, gastrointestinal, each of whom does special tests and returns her unimproved. In desperation he may finally send her to the psychiatrist, who, making a global health assessment, discovers she has an ineffective husband, lives in an unhealthy condemned house with children with health and schooling problems, has very little money and constant struggles with unsympathetic minor officials. Her symptoms bring her rest-pauses in her struggles and are cries for help, not pathological indicators. Sympathy, encouragement, practical suggestions from an effective husband–father figure help her where biochemistry fails.

In 'The chronic somatizer and the Government White paper' (*Journal of the Royal Society of Medicine*, April 1990, **83**, 203–205) Dr Christopher Bass, with Dr M. Murphy of King's College Hospital, draws attention to the many patients attending general hospitals who express their psychosocial distress in the idiom of bodily complaints; they think far too few of them ever see a psychiatrist, but become permanently disabled and soak up benefit money, as well as consuming much laboratory time and specialist effort. Even among psychiatrists these patients are too often misdiagnosed and ineffectively treated as "mood disorder"; they, and GPs, need to learn the psychosocial analysis and form of psychotherapy which will really help to content the patient. The biomedical model of practice prevents these approaches, and it is possible that the numbers of such somatising cases will increase and eventually prove a public health problem, as in the USA.

This paper is important both in drawing notice to a neglected but important category of clinical case and its treatment and in showing up a gross philosophical flaw in the plans for the new NHS. There may well be other aspects of daily psychiatric practice which need detailed examination in this way to see how the changes in finance will hit them. How will competition and financial stringency change the work of the psychiatric ward, the day centre and the follow-up clinics? We need to keep on reminding managers and administrators, and our medical and surgical colleagues, that patients are (complex) humans, not automobiles. We shall have to be alert to finding new ways of helping our patients through the gaps in restrictive regulations and in capturing resources.