EDITORIAL

FAMILY MANAGEMENT IN MEDICAL PRACTICE: THE PSYCHOSOCIAL-MEDICAL CONNECTION

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The social work – medical practice overlap

Social workers are well aware of the overlap between their clients and medical patients. In recognition of this fact, hospitals have long included social workers in their staff complement. Similarly, workers in social service settings know that many of their clients have medical problems. The medical problems may be the cause of their social problems or may have developed subsequent to the social problems.

How much overlap is there? Percentages are not easily available. I suspect that the numbers will vary from area to area, from country to country, depending on diverse factors such as the unemployment rate, health and housing status, the diet and smoking habits of the population and the status of women.

Corney[1] stressed the need for increased collaboration between workers in medical and social work. However, although she states that there is a large overlap in the populations attending at general practitioners' clinics and social services, no figures are presented.

General practitioners can be expected to see the greatest number of patients who present with symptoms which are not of organic origin. When asked to estimate what proportion of their patients have no demonstrable pathology, I have been surprised that they consistently come up with the word "Half". It is probably not coincidental that De Lozier[2] in a different country, at a different time found that "out of 100 encounters with the family physician, there is no objective evidence of pathology in 50, 35 being psychosocial problems involving feelings or emotions, 10 being visits for prevention-oriented services, and 5 for the other services that the doctor is sanctioned to provide."

Health and family

Campbell's exhaustive review[3] of the family's impact on health describes family problems causing illness and chronic illness causing family problems. Every organ system is affected; and mental illness too is very highly affected by family situations.

The association between stressful events and the family was shown by Holmes & Rahe[4] who listed the events with the 5 highest ratings out of 43 events in their social adjustment rating scale as death of spouse, divorce, marital separation, jail term and death of close family member. Four out of the five are family-related events.

Rosengren et al[5] demonstrated the correlation between stressful life events and mortality in a cohort of 1,016 men born in 1933 followed-up for 7 years. The all-cause mortality for the group of 101 men who had 3 or more life events was 10.9%, significantly higher compared with 3.3% for those with no life events (p=0.03).

Medical-psychological overlap

What is the overlap between the psychological origins of disease and the psychological effects of organic illness?

Lask and Fosson[6] "believe that it is more logical and sensible to think in terms of a continuum of illness or disorder, from predominantly organic aetiology on the one hand, to predominantly psychosocial aetiology on the other. Such a view allows the appropriate emphasis, but does not exclude the possibility (and in some instances the probability) of additional aetiological factors."

Wood[7] similarly argues for the recognition of a "biobehavioural continuum of disease", a sifting of the psychosocial influence and the biological influence in psychosocially manifested disease as well as in physically manifested disease.

The cost effectiveness of psychological interventions

Psychological interventions such as individual counselling, family or marital therapy require more time per session than the average medical consultation. It is therefore not surprising that these interventions are seen as expensive by patients as well as hospital administrators. Doctors who see 5 patients a day for therapy will compare unfavourably with their colleagues who see 25 patients within the same period. It is helpful to view psychological interventions in the light of total expenditure of time and of money for a particular problem.

Cummings et al[8] in The Hawaii Medicaid Project which involved 16,368 Medicaid and 28,277 Federal employee patients addressed this very issue. They found that voluntary acceptance of additional "targeted, focused" treatment led to savings of 18% to 38% of total health care expenditure for various segments of the study population over the 12 months after the additional treatment compared with the expenditure for the year before treatment. In other words, adding psychological intervention to existing medical treatment effected savings in the long term.

Doctors and the families of patients

Doctors have long been very willing and able to recruit family members to help with the care of the patient, and rightly so. They are also often aware of family problems which contribute to a patient's illness, but do not see the relevance nor have adequate skills to address them. This is true of general practitioners as well as specialists because, in the Singapore context, patients often seek consultations directly with specialists. These patients are likely to be skewed towards those with psychosomatic symptoms because they are the ones who are more likely to have felt dissatisfied with the outcome of medical treatment by their general practitioners. If it is true that psychosomatic complaints account for half the symptoms presenting to general practitioners and perhaps not much less

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than half of those presenting to specialists, and the doctors are not adequate to the management of such complaints, there is either a serious lack in the undergraduate medical curriculum or a serious mistake in the treatment channel of large numbers of patients. In any case, there is obviously a great need for psychologically based management for a large proportion of patients who are seeking treatment from doctors. The psychological treatment, such as counselling, should be conjoint with, rather than instead of, medical treatment. How can this be done?

Services for families within medical practices

There are at least two ways of making psychological services available to patients where they are, that is, in the doctor's office. Firstly, management of psychosomatic symptoms by the doctor is not as difficult as it sounds. Many experienced doctors have discovered ways of doing it on their own, without formal training. Others could learn basic counselling skills in the same way that they take upgrading courses. To overcome the problem of longer consultations, doctors should schedule separate and longer consultations together with a contract for a higher fee. It will be cost effective and satisfying for both patient and doctor because the patient will recover more quickly and the doctor will have the satisfaction of giving appropriate and successful treatment.

Secondly, there are models of family therapy and counselling clinics which are located within group medical practices where patients with problems of family distress and marital strife are referred. To work well, mutual respect between the practitioners of medical and psychosocial disciplines is required. Graham[9], a general practitioner, describes a young woman who had been ill and dependent with chronic fatigue for 5 years before her family was engaged in family therapy by the author. She regained an active and independent life after 8 sessions of therapy.

For doctors who prefer to refer family cases to therapists, Senior[10] reports on the experience of practising family therapy in a group practice setting where "We have a clinic here on Friday afternoon....". Dimmock[11] reports a 7-year collaboration between family counsellors with social work backgrounds and a group general medical practice in his Gloucester Project. The major advantage of this arrangement is that the doctors and therapists are able to consult and keep in close touch with each other to the benefit of the patients. Outpatient clinics in Singapore, both in primary care and in hospitals, could benefit their patients with a similar arrangement. The overall cost effectiveness of treatment would probably be improved as well, but this issue needs to be proven by a controlled trial in a Singapore setting.

Psychiatric hospitals have already discovered the value of family clinics. For example, patients with schizophrenia suffer a high relapse rate in spite of drug treatment. Their families suffer severe disruption, the most difficult to bear being unpredictable threatening behaviour[12]. Hogarty et al[13] reported the 1-year outcome in 103 patients with schizophrenia who had various social and family interventions in addition to drug treatment. The relapse rates for the drug-compliant patients were 11% for family treatment, 17% for social skills, 0% for family treatment plus social skills, and 32% for controls who were on drug treatment only.

Conclusions

Awareness of a patient's family situation is an important facet of a doctor's skill. To address the problems of family or marital dysfunction and distress in the many patients with chronic organic illness and non-organic illness, psychology-based methods of management such as individual, family or marital counselling is a valuable addition to medical treatment. The "verbal cure", undertaken in the right circumstances, can hasten recovery or effect a cure where medical treatment is only palliative. However, just as there should be proper indications for medical investigation and treatment, counselling and therapy must also be judiciously used because "The tongue that brings healing is a tree of life, but a deceitful tongue crushes the spirit." (Proverbs 15:4, The Bible.)

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