BRITISH MEDICAL JOURNAL

LONDON SATURDAY JULY 30 1938

THE MENTAL FACTORS IN MEDICINE*

BY

T. A. ROSS, M.D., F.R.C.P.

In the year 1920, at Cambridge, I had the honour to open a discussion on this subject in the Section of Psychiatry. On that occasion Sir Arthur Hurst said that the debate was being held in the wrong place—that it should have been held in the Section of Medicine. At that time it seemed an extravagant saying, and yet we are here to-day. Eighteen years does not seem so very long for the seed which Sir Arthur sowed to have grown thus high; for though we have not yet converted all the physicians we have at least been allowed to found a mission in their territory.

The Frequency of Neuroses

Approaching the neuroses as I did from the field of general medicine, it has always seemed to me of importance that they should not be regarded as belonging to one specialty. These conditions are found in people who present symptoms relating to any part of the human organism. They may be mental symptoms and resemble those of a psychosis, or cephalic and resemble those of a neurological lesion, or circulatory and be like those of heart disease, or ocular, or digestive. These symptoms may be of as great magnitude as those of physical disease. They may cripple as much as physical disease. Neurosis is the great mime, and therefore it is desirable not only that this should be recognized by every member of the hospital staff, as it probably is, but also that in teaching hospitals the person who demonstrates cases with any symptomatology whatever to students should be prepared to give or to arrange for instruction on examples of neurosis as they occur; for it is certain that unless the student receives instruction in these disorders he will be turned out an ill-educated doctor. It may be said that this is being done, that many hospitals do now teach this subject in a special psychiatric department. For many reasons this is insufficient. If it is the method employed the student gets the impression that the neuroses are exceptional happenings, to be treated only by specialists, and this is exactly the opposite of what he should be taught. The neuroses are probably the commonest single cause of ill-health; their incidence in all illness has been estimated at something between 20 and 40 per cent. by various workers in this country and America. The statistics have been summarized in an admirable paper by Bruce Pearson (1938). Therefore, throughout his clinical instruction the student should learn daily and not occasionally that neurosis is common.

Again, with regard to these disorders the psychiatrist is not the ideal person to teach. The psychiatrist is usually a man who has specialized early. He cannot be familiar

with the protean forms which these conditions may take. His knowledge of the somatically presenting neuroses is apt to be mere hearsay. He is interested, so far as neurotics are concerned, with the more nearly mad than the more nearly sane. There is nothing in his study of insanity which will lead him to understand the neurotic mind more fully than will a man brought up in general medicine, and the mere fact that the cases are referred to him must lead the student to think that a specialist is the only person fit to deal with them. If this were true the number who could be treated would be negligible. If we must have specialists we were better off with the neurologists. All the useful forms of treatment of these disorders were given to us by neurologists.

Certain Difficulties

There are some difficulties in the way of making every teacher a teacher of the neuroses.

1. Physicians and surgeons have on the whole a dislike of psychology and of neurotic patients.

2. More and more the teachers of students are specialists, so that more and more students are taught very thoroughly about diabetes, pernicious anaemia, rare neurological conditions and the like, and less and less about common illnesses, and therefore they do not tend to see examples of neurosis in the wards, with perhaps the exception of gross hysterical paralysis.

3. Students are being taught both by precept and example to depend much more on apparatus and less on clinical histories and clinical signs and symptoms than formerly. That which cannot be demonstrated by apparatus tends to get neglected.

Therefore, when a student is launched into practice and finds that in a large proportion of his patients he can find nothing amiss physically he is at once confronted with difficulties, which with his present kind of education may be very puzzling.

The "Negative" Diagnosis

The young doctor, having been taught to rely so much on machinery and so little on his own powers of clinical observation and judgment, has a great deal more difficulty than had his forefathers in coming to a conclusion that a patient has nothing wrong physically. As will be emphasized later, the conclusion that there is nothing wrong physically is not the point of importance in the diagnosis of neurosis, but it is extremely important that the doctor should be able to make up his mind that there is nothing physical which can account for all these symptoms. If he has no access to the machines he may soon be quite lost. If he has access, and is conscientious, and if he pursues the matter far enough, he may in time learn from some laboratory or some specialist that a lesion of some kind, which may, however, be quite irrelevant to the symptoms, does exist; and if he has learned

* Read in opening a discussion in the Section of Medicine at the Annual Meeting of the British Medical Association, Plymouth, 1938.

no psychology he is bound to seize on this and treat it, sometimes with success, sometimes without. Even if successful immediately he may have harmed the patient for the future by letting him think that an unimportant lesion like the one discovered could have caused so much ill-health, with its devastating corollary that one cannot take too much care of very small departures from the normal. On the other hand, after exhaustive inquiries—exhaustive especially to the patient's purse—he may be able to assure himself that there is nothing wrong physically. He will now hopefully and enthusiastically impart the glad news to the patient, but not add anything to this purely negative thing, which really conveys nothing in the way of information; and he is apt to be disappointed when the patient continues to be as ill as before, as loud in his complaints. His disappointment will probably deepen into annoyance when he hears some months later that this ingrate has been cured by an osteopath or a nature-curer or by any other of the unqualified people who take the opportunity once more to score over medical science, not realizing the vitreous nature of the houses they themselves inhabit. Our doctor may even become bitter enough to think that this irregular cure was spontaneous. There are of course spontaneous cures, but the doctor is more apt to think it for these than he does for his own.

It is fairly obvious why a purely negative diagnosis, a diagnosis that there is nothing wrong, is unlikely to help a patient. He feels ill, and to be told that these symptoms mean nothing is to infer that he is imagining them, and he knows that he is not. He is therefore driven to suppose that the doctor has not understood the case. If the doctor has been careless the patient can, of course, transfer to another, but if the doctor has been careful it may be that the only change open to him is to change the system, to go to someone who is not a doctor and who openly preaches that doctors know very little. Such a one will not make the psychological error of saying that there is nothing wrong. He will find poisoned blood, or pressure on nerves and circulation, or faulty posture, and by his certainty will inspire the patient with hope, for the time being at least. That the immediate good results obtained by these people are genuine I have little doubt; that their remote results can be good I have the gravest doubts. I am certain that their good results are due to the psychological factors of faith and hope; but faith and hope are not of themselves enough for lasting cure. I am of opinion that one of the reasons why quacks flourish is that they are better psychologists than most doctors. That is not the whole reason, which would take too long to go into, but it is an important one. These patients have something wrong, but it is not physical; it is something of the nature of mental disharmony. Most physicians will agree, but they do not teach their students how to investigate this matter as they would teach them how to investigate a cardiac irregularity.

There is, however, another and fundamental reason for the futility of regarding the neuroses negatively. When we come to examine these patients from a mental aspect—that is to say, when we take their histories—we find that their symptoms are the positive responses to anxieties, conflicts, and the like, of exactly the same order as symptoms may be the positive responses to physical stimuli. We have as a profession learned much of the action of physical irritants; we must now turn our attention to symptoms produced by mental irritants. We shall then find that there is nothing negative about the neuroses, any more than there is in physically determined illnesses.

In every case of illness there are three questions to be answered: Are these symptoms due to physical irritants, to mental irritants, or to both? No diagnosis is nearly complete till they have been answered.

The "Fancy" Diagnosis

So much for the conscientious doctor who, when this sort of thing happens often enough, may become less so. One not very good at the beginning, finding nothing that he had been taught to look for, may make a fancy diagnosis on no particular kind of evidence—a weak heart or, more fashionably just now, a gastritis. His treatment may be followed again by immediate success; neither he nor his patient has the faintest inkling that this may be due to the mental healing factors of faith and hope. Even if he succeeds in his treatment he has damaged both himself and his patient—himself because he has started on that downward path which leads to the belief that accuracy of diagnosis does not matter so long as the patient is told something definite: it is good if the diagnosis is correct, but not dreadfully bad if it is not. He has damaged the patient, who has been told that some organ of his perfectly healthy body is not quite healthy and who must now believe that he ought to take care of it; and whosoever starts taking care of a healthy body will soon have plenty of illness.

There is another unpleasant thought about all this. In all these ways doctors are regularly adding to the quantity of neurosis in the world instead of diminishing it. They do so if they succeed in the way just mentioned. They do so if they fail, because the patient soon loses faith in his doctor, gets bewildered, and is driven deeper into neurosis. I have said that neurosis is common, and I must add that it is lamentably common from this cause. A patient has symptoms caused by anxiety. The doctor says it is due to some physical lesion. The patient becomes anxious about this. The anxiety causes more symptoms, and this helps to fix the belief in physical disease, and so on *ad infinitum*.

So much for pure neurotics. But in addition to them many sick people will add mentally determined symptoms on top of a physically determined one. Anxiety from many sources is apt to complicate illness, especially chronic illness. And in many instances of organic disease the only treatment we shall be able to give will be psychological.

Teaching the Next Generation

I should like now to leave my young doctors and get back to the wards and try to plan how the next generation is to escape the mess that these poor young men are in. At once the questions arise: Where are these students to be taught, by whom, and what are they to be taught?

The answer to the first two will probably be that that is arranged for already—namely, in the psychiatric department by the psychiatrist. And my reply is that it is not good enough, for many reasons, some of which have been given. The question of neurosis must be raised often all over the hospital. The student must continually be made clinically aware of its possibilities as regards symptoms, and every teacher ought to be able to say something about the elements or principles of treatment. Now what is to be taught?

A physician of my acquaintance told me that it was high time we psychological people put our house in order, and I would respectfully ask those of our medical friends who acknowledge that we have a case to help us to present it properly, as they have done with other

technicians like surgeons and bacteriologists. They do not give these people a free hand with their patients, but call them in, consult with them, and then use them or not as seems fit.

There is an idea abroad that no psychological treatment except psycho-analysis is worth talking about. I have spent my life in trying to show that this is not true. I am saying nothing against psycho-analysis, which is probably the best treatment for certain cases, but there are a great number of patients who do not need it, for whom something quite simple is all that is required. I have no wish that medical students should learn analysis. It would be impossible for them to do so even if it were desirable. Time would make it so. For the same reason, even if psycho-analysis were the only psychotherapy, mental treatment would be impossible for the majority of patients. In my view there are, and have been for a long time, simpler and shorter methods of psychotherapy which are at least as old as Freud's system, and of which the greatest exponent was Dejerine of Paris. This depends on the fact that many symptoms are caused by conflicts and anxieties which are not necessarily unconscious in the Freudian sense, but which are not being faced properly. Taking a full history, in the course of which the patient may be induced to speak of these worries, be guided about them, have many of them explained so that they no longer cause anxiety, will in many instances bring about a great change for the better in the patient's mental outlook and in his health. Many of these anxieties will be on intimate personal matters, and talking about them will often give relief. Many will be about disease and health. It is incredible what extraordinary views people hold about health in general and their own in particular; and here it is that doctors should be more careful than some of them are in telling patients that they may have frail or impaired organs when the real truth is that these doctors themselves are unable to make a diagnosis. For the same reason students should be taught, when there is physical disease, not to put the gloomiest possible view before the patient, a thing done often with the best intentions so as to bring a patient to take some care of himself, but which may be followed by disaster.

There is one essential—namely, that the patient and the investigator must be alone together for their talks. People will not speak of intimate things before a crowd. Therefore it cannot be demonstrated to students how to do it; but students could be told the procedure and be supervised while they were learning to practise on patients. There will be cases which such a procedure will not cure; these are for the specialist. We expect a general practitioner to treat many dyspepsias, kidney diseases, headaches, and catarrhs by himself, and not to run to a specialist for every one. But there will be dyspepsias, headaches, and catarrhs for which he will need a specialist, and we expect him to learn which are those that he can treat himself and which are those where he should seek special skill. The same thing applies to the neuroses.

The Teachers

Who is going to teach the students? Time is needed. There should be someone who can teach them as clinical tutors teach them physical signs. These teachers may be under the psychiatrist; but whoever is at the head of this department should not be locked away in the department of psychiatry, but should be asked to come to the wards and consult with the physicians and surgeons as to whether there is a large emotional element in this case

or not. The medical or surgical chief and the student will then not lose sight of the case as they will if the patient is dismissed to the psychiatric department because the general ward has got tired of him. If I am told this is impracticable I answer that nothing is impracticable which has been done and is done. Dejerine did it in his wards, and said that he got better results than in private practice. It is being done in America, and an extremely vivid description of the psychiatrist being welcomed in the general wards and consulted frequently has been given by J. Kasanin of Chicago (1937).

REFERENCES

- Kasanin, J. (1937). *Lancet*, 2, 1518.
Pearson, Bruce (1938). *Ibid.*, 1, 451.

THE VALUE OF RADIOLOGY IN THE ELUCIDATION OF HAEMOPTYSIS*

BY

FRANKLIN G. WOOD, M.B., D.M.R.E.

*Radiologist to the London Chest Hospital, Victoria Park,
and to the German Hospital, Dalston*

Haemoptysis is an important symptom in diseases of the chest, and was formerly considered to be a certain indication of pulmonary tuberculosis unless the contrary could be proved. We know now that it may be a symptom of any chronic or acute disease from simple bronchitis to lobar pneumonia.

Haemoptysis in Pulmonary Tuberculosis

If pulmonary tuberculosis has been responsible for a haemorrhage from the lungs, a chest skiagram will nearly always supply evidence of this disease. But it sometimes happens that although the history and symptoms are suggestive of pulmonary tuberculosis, a skiagram fails to show any abnormality. It appears probable that this may be explained by the presence of a small focus of disease which either proves abortive or goes on subsequently to the development of a more obvious lesion. It is desirable, however, that a very careful radiological examination should be carried out, since a tuberculous focus, or even a small cavity posterior to the lung root or heart or behind the domes of the diaphragm, may be easily missed. The investigation should include a screen examination and radiographs taken in the oblique and lateral positions. The semi-oblique position, with the patient rotated so that the clavicle on the side to be examined is parallel with the cassette, is of special importance in demonstrating lesions in the vicinity of the lung root. Radiographs taken with the Potter-Bucky diaphragm or a fixed grid of the Siemens or Lysholm type are also of value, especially in stout patients.

The invention of tomography has considerably enlarged the scope of the radiological examination of the chest, and I think that in the future it will prove a method of considerable interest in the examination of cases of haemoptysis with no obvious lesion in the lungs. As some of these patients subsequently develop a lesion which can be demonstrated radiologically, it is important to carry out serial radiographs at intervals to exclude the presence of disease.

There are many other conditions besides pulmonary tuberculosis which may cause haemoptysis, the most

* Read in opening a discussion in the Section of Radiology at the Annual Meeting of the British Medical Association, Plymouth, 1938.