Book

On the soma side of the street

Is there anyone who does not acknowledge the importance of psychological or social factors in medical care? Is there anyone left who does not accept that if you want to improve the quality of life and functioning of those with chronic or complex medical problems you need to treat not just the disease, but the person with the disease? It seems there must be, otherwise there would be no need for this book.

Fritz Huyse and Friedrich Stiefel have put together a coherent and evidence-based case for the "integration of the biological, psychological and social" in the care of those with chronic diseases. They call this "integrated medicine". But why the need for a new term? The case for a truly integrated medicine was most famously articulated by George Engel when he advocated a "biopsychosocial approach" to patients' care in 1977, and as the authors admit, what they are doing is largely updating Engel's ideas for the era of managed care, which means adding some economics to an already powerful case.

So why does integrated medicine need to reinvent itself once more? The first efforts to unite mind and body in the practice of medicine began during the 1920s and 1930s with the psychosomatic movement. However, its heavy psychoanalytic influence proved to be unpalatable for most physicians. This movement also never recovered from making overhyped claims for a psychogenic aetiology of various conditions, such as ulcerative colitis, rheumatoid arthritis, and asthma. By perpetuating the idea that the origin of such diseases really was "all in the mind", the psychosomatic movement took a body blow when this proved to be palpably untrue. Today the word psychosomatic remains etymologically impeccable, but practically useless, since in popular usage psychosomatic is all psyche and no soma.

Psychosomatics gave way to consultation liaison psychiatry, which had more modest but achievable goals—principally to improve the care of medically ill patients. And across the spectrum of medical care, from the metabolic syndrome, via care of the elderly, to the haemodialysis unit, this book shows clearly and repeatedly the folly of ignoring the psychological in medical practice. Once again the Cartesian dragon is well and truly slain. But is anyone listening? Apparently not, since, as this book tells us, "the psychological and the social systems of the patient continue to be split off, despite 50 years of the biopsychosocial model". We still have mountains to climb before achieving a truly integrated medicine.

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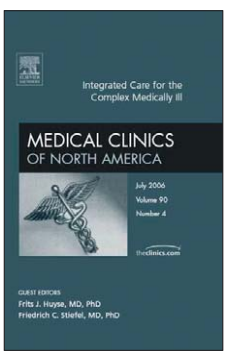
And the size of that mountain is illustrated by the hill where I work: Denmark Hill. For those unfamiliar with London topography, Denmark Hill is a street that dissects the London Borough of Camberwell. On the left hand side is the Maudsley Hospital and the Institute of Psychiatry. On the right hand side is a large general hospital, King's College Hospital and part of its medical school. Perhaps 3000 people work on the campus on opposite sides of the road. Most belong to the mind on the left or the body on the right. Few belong to both. Of course, it is not that simple. It would spoil my rhetorical flourish to admit that the Institute of Psychiatry is overflowing with neuroscientists of every shape and form, or that many of my colleagues deliver psychological services within the general hospital. On the other hand, as I write this review we, like so many others in the UK's National Health Service, are being forced to make large-scale "cost improvements", and one of the things that will be "improved" is our liaison service by losing several key members of staff. The same is happening to the Oxford liaison psychiatry service. When the chips are down, cuts fall disproportionately on those who straddle the physical/mental divide.

Medical services continue to be organised to encourage dualism. Like most of the contributors to *Integrated Care for the Complex Medically Ill*, my clinical specialty is in liaison psychiatry. My particular interest is those grey areas that lie between medicine and psychiatry—a professional space in that dangerous zone in the middle of the street, and at times it feels that way. We currently call these the unexplained symptoms and syndromes, the latest in a long line of failed attempts to find satisfactory descriptive labels for these conditions. Many of my patients tell me about their physical symptoms—fatigue, pain, weakness, tremor, abdominal disturbances, and so on. These patients will be seen on the soma side of the street, to paraphrase the old Tin Pan Alley song. But if I show interest, they will soon admit to complex emotional lives and distress. Meanwhile, on the Maudsley side of the street, patients talk about their sadness, fear, anger, frustration, anxiety, and occasional despair. But if anyone bothers to ask, it is a rare person who does not admit to often disabling physical symptoms. When it comes to symptoms, mind and body are inexplicably intertwined. As Kurt Kroenke and Judith Rosenblum articulate in this book, there is "no area of medicine that requires tearing



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Frits J Huyse, Friedrich C Stiefel, eds. Saunders/Elsevier, 2006. Pp 240. US$83·99.
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down the walls of mind-body dualism more than the interface between somatic and psychological symptoms. Integrating medical and psychiatric care is essential to the patient-centred and cost-effective care of symptoms".

But it is not so easy to cross the mind-body divide, and join the two sides of Denmark Hill together. Patients seem to be more comfortable on one or other side. In mental health and general practice settings patients often react with disdain to somatic interventions, such as antidepressants, preferring to see counsellors and not to "mess with my brain". And on the soma side of Denmark Hill, in the general hospital, the reluctance of some patients with unexplained syndromes to engage with psychologists or psychiatrists is well known, although at the moment it is these disciplines that offer the most successful treatments. But that does not apply to all. Cancer patients across the country lobby for better psychological care. At King's we have heeded Leonard Egede's call in this volume for better integration of the physical and psychological into diabetes care, and the new service is immensely popular.

But acceptance of psychological therapies in the oncology clinic or psychiatrists in medical outpatients does not represent the end of dualism. Cancer patients do not lobby for psychologists because they believe that psychological factors are the cause of their cancer. They feel it is safe to engage with psychological therapies precisely because their doctors do not hold with psychosomatic theories of cancer. Once the physical basis of disease is established, then one can explore the psychological, but not before. This is the paradox that the contributors to this otherwise excellent monograph do not confront. Ironically, perhaps the best way to improve the psychological support for, and understanding of, patients with a range of illnesses is not to try to combine mind and body. Medical care remains fundamentally dualistic. No matter how overwhelming the evidence, we still seem best able to tackle the social and psychological only when we have solved the physical first.

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The Last King of Scotland
Directed by Kevin Macdonald. Based on the novel by Giles Foden. Fox Searchlight Pictures, 2006.

In brief

Film Doctor to a dictator

The Ugandan dictator Idi Amin insisted on being called many things: His Excellency President for Life, Conqueror of the British Empire, and Lord of all the Beasts of the Earth and Fishes of the Sea. The man, who butchered 300 000 of this own people in the course of his 8-year rule, also went by "Dr Amin". This honorific is relevant in *The Last King of Scotland*, a film that depicts Amin's tenure through the eyes of a (fictional) Scotsman living in Uganda, but not because Amin lays claim to it. A young physician named Nicholas Garrigan (James McAvoy) does, even after he abandons his humanitarian work in a village to abet one of the most murderous tyrants of the 20th century.

The story begins in Scotland in 1970; Garrigan has a freshly issued medical degree and a wide-open future. He takes a post in rural Uganda, where exotic environs and (this being the pre-AIDS era) sexual exploits await. "Whatever I can do to help", Garrigan says cheerily on his first day at the village clinic. But he's in for a rude awakening: the work is hard, and most of the locals prefer the witch doctor. Worse yet, the only female expatriate in town (Gillian Anderson) spurns his advances. So when a chance encounter with the country's new headman leads to an invitation to the capital, he is happy to skip town.

Like Garrigan, Amin—played with an unnerving intensity by Forest Whitaker—is a brash, charismatic type who likes a good time. He also needs a personal doctor with no ties to the previous regime. Amin dispenses a little charm, offers Garrigan a posh bungalow, and the good doctor is soon on board.

Garrigan offers advice here and there, but spends most of his time living the high life and, when necessary, defending his boss to the press as Amin solves political problems with machetes and dynamite and descends into madness. But before Garrigan knows it, a process of elimination has made him Amin's "closest advisor"; and when he decides, after finally realising he's got blood on his hands, that he'd like to return to Scotland, he's not exactly free to go.

This cautionary tale, of how good intentions are betrayed by the callowness and naivety that often hide behind them, dramatises how in volatile Africa, the tie that binds medicine and politics is, tragically, sometimes soaked in blood. The film, based on Giles Foden's acclaimed first novel, takes to task the gap-year adventurer with a vague desire to help those in need. Doctors, it suggests, can shed that desire as readily as anyone else.

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