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PSYCHIATRIC ILLNESS AT GENERAL HOSPITAL CLINICS

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PATIENTS suffering from a psychiatric illness often present with many bodily complaints. It is not surprising to find, therefore, that these patients are sometimes referred to the general hospital clinics for the investigation of somatic disease. The aim of this paper is to review the subject, describe an investigation at a general hospital clinic and to discuss the various problems raised.

Relatively few investigations have been made into the problems presented by psychiatric patients at the general clinics, though it is a large and important one. Table 1 shows the reported incidence of psychiatric illness among medical out-patients. The mean is 27.3%. Patients with concurrent organic and psychiatric illness account for another 10 to 40% of the patients seen in the different surveys.

TABLE 1

PREVIOUS REPORTS ON INCIDENCE OF PSYCHIATRIC ILLNESS IN 'NON-PSYCHIATRIC' PATIENTS

Author	Place	Number of Patients	Percentage with Psychiatric Illness
Allan and Kaufman (1948)	Lahey Clinic	1,000	27
Buck (1930)	Boston	2,000	36
Hamman (1939)	Johns Hopkins	500	23
Lewis (1952)	Iowa	151	20
Lewis (1953)	Johns Hopkins	163	49
McLean (1932)	Chicago	100	27
Moersch (1932)	Mayo Clinic	500	12
Pearson (1938)	Guy's Hospital	1,297	16
Pemberton (1951)	Sheffield	146	17
Reynolds (1930)	Johns Hopkins	935	21
Roberts and Norton (1952)	New Haven	50	52
		Total 6,842	Mean 27.3

These figures refer to patients whose illness was considered entirely psychiatric. Patients with concurrent organic and psychiatric illness account for another 10 to 40% of the patients seen in the different surveys.

Surgical out-patients have not been studied to a similar extent though Zwerling, Titchener, Gottschalk, Levine, Culbertson, Cohen and Silver (1955) considered that the mental health of only 1 in 10 of 200 surgical patients was satisfactory. Bryson (1945) reported on 2,320 gynæcological patients: 348 were thought to have a functional illness; 932 an organic illness; and 1,040 had abnormalities in both fields of study. Thus 59.8% of the patients needed some psychiatric understanding. Morris and O'Neil (1958) saw 60 women attending a gynæcological clinic. They concluded 'that emotional tensions outweighed physical malfunction and disease as a cause of illness in the patients seen'.

Consideration of these papers supports the conclusion of a B.M.A. Committee (1941) which stated 'that in any group of sick people something like 30% will be found to be suffering from conditions about which it is helpful to have psychiatric advice'. Such psychiatric advice has not, until recently, been readily available at general hospitals. It is not surprising to find that little information is given in the above papers (mostly written by physicians) as to the type of psychiatric illness seen, the social problems presented by the patients, the treatment needed and the outcome of the illness. It was in an attempt to answer some of these questions that the investigation described here was carried out. (Culpan and Davies, 1960).

Investigation

While acting as a psychiatric registrar at a general non-teaching hospital, it was possible for me to see a number of new referrals to the general out-patient clinics. At the medical clinics, after the physician had seen each new patient, he told him that he wanted another doctor to see him, but it was not mentioned that I was a psychiatrist. The patient was then seen for 20 to 30 minutes and after some questions about presenting symptoms, an attempt was made to get him talking about various aspects of his life. The presence or absence of psychiatric symptoms was noted. With the physician's findings available a

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diagnosis was made of organic illness only, psychiatric illness only, or a mixed syndrome.

One hundred consecutive new referrals to the medical out-patient clinics were seen in this way. Table 2 shows the incidence of psychiatric illness in these patients.

TABLE 2

INCIDENCE OF PSYCHIATRIC ILLNESS IN 100 CONSECUTIVE NEW REFERRALS TO A MEDICAL OUT-PATIENT CLINIC

No. of Patients	Organic	Mixed	Psychiatric	Not Diagnosed
100	43	13	38	6

Later the patients with psychiatric and psychosomatic illness were seen for further interviews so that they could be studied in more detail.

A similar survey by Culpan of 100 new referrals to the surgical out-patient clinics at the same hospital gave the incidence of psychiatric illness only as 5% (Table 3).

TABLE 3

INCIDENCE OF PSYCHIATRIC ILLNESS IN 100 NEW REFERRALS TO A SURGICAL OUT-PATIENT CLINIC

No. of Patients	Organic	Mixed	Psychiatric	Not Diagnosed
100	66	16	5	13

Patients with psychosomatic diseases (peptic ulceration, thyrotoxicosis, etc.) were classified as organic if no formal psychiatric conditions were present (24 at both clinics) while seven others were allocated to the mixed diagnostic group.

As expected, the commonest symptoms seen in these patients were anxiety and depression, symptoms associated with an affective disorder. In the medical patients 51 of the 100 patients had psychiatric symptoms and in 37 of these the diagnosis was an affective disorder. In 17 of these depression was the main feature of the illness. Many papers have recently drawn attention to the importance of recognizing and treating patients with a depressive illness. Ziegler (1939) described 111 depressed patients who went first to a surgeon or physician for the relief of bodily symptoms. 'These patients', he writes, 'were grossly and universally misunderstood. Depression was not usually the first manifestation of the disorder. There was, first, fatigue, loss of appetite, weight loss and sleeplessness. Depression, anxious concern about self, shame and melancholy came later. In addition, unusual bodily sensations occurred, often leading the patient from doctor to doctor in vain attempts to locate the trouble with laboratory tests'.

At interview, information was obtained from the patients concerning current social difficulties. No objective assessment of these was possible but Table 4 shows the incidence of these among the medical out-patients.

TABLE 4

INCIDENCE OF SOCIAL DIFFICULTIES REPORTED BY 100 MEDICAL OUT-PATIENTS

	Organic Illness		Psychiatric Illness	
	Men	Women	Men	Women
Per cent. reporting social difficulties ..	12.5	26.2	76.9	60.0

As will be seen, social problems are frequently reported by the patients with a psychiatric illness. Like Pemberton (1951) it was found that some disturbance of interpersonal relationship in the family circle was the commonest difficulty but death or severe illness of the spouse or near relative was also frequent.

What kind of treatment did these patients with a psychiatric illness appear to need? Only my personal opinion can be given. Of the 51 patients at the medical clinic with a psychiatric illness, 14 needed a full physical examination, reassurance about the absence of organic illness and an explanation about the relationship between anxiety and symptoms: 19 patients appeared to need supportive treatment—i.e. regular, brief talks with an interested doctor and perhaps mild sedative or stimulant drugs; in other words, family doctor treatment: 18 of the patients appeared to need more complex psychiatric treatment than the general practitioner could be expected to provide. Among the surgical patients, 10 appeared to need additional psychiatric help.

A short term follow-up was possible on the patients at the medical clinic with a psychiatric illness. Between three and six months of their first attendance 52% of these patients had improved and were virtually free from symptoms. A longer follow-up was not possible in the present study.

Macy and Allen (1933) draw attention to the surgical hazards of a neurotic illness. They followed for six years 235 patients diagnosed at the Mayo Clinic as having a neurotic illness. They found that 200 of these 235 patients had had 289 separate operations (particularly tonsillectomies and gynæcological operations). In the majority of cases these operations did not relieve the symptoms they were designed to cure.

Discussion

The review of the literature and the investigation described show the importance of psychiatric

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TABLE 5
COMPARISON BETWEEN MEANS FOR TOTAL C.M.I. SCORES

Groups		Number	Mean Scores	Difference between Means	t.	P.
(A) FEMALES						
(*a*)	Neurotic control group	72	45.6	24.8	7.1	<0.001*
	Normal control group	56	20.8			
(*b*)	'Organic' medical patients	22	21.0	19.2	3.40	<0.01*
	'Psychiatric' medical patients	24	40.2			
(*c*)	Neurotic control group	72	45.6	5.4	0.98	>0.05
	'Psychiatric' medical patients	24	40.2			
(B) MALES						
(*a*)	Neurotic control group	46	32.5	21.5	7.55	<0.001*
	Normal control group	48	11.0			
(*b*)	'Organic' medical patients	19	14.7	14.4	2.90	<0.01*
	'Psychiatric' medical patients	13	29.1			
(*c*)	Neurotic control group	46	32.5	3.4	0.59	>0.05
	'Psychiatric' medical patients	13	29.1			

* Significant at 5% level.

illness at the general out-patient clinic. These patients form only a small part of the problem of psychiatric illness as it presents to the family doctor. Most of these patients he diagnoses correctly and treats himself, while a few he will refer to psychiatrists. Patients seen here were referred to 'exclude' organic disease. Of the 38 patients at the medical clinic with a psychiatric illness, only 16 of the referring letters mentioned that the patient was anxious or under stress, but in addition most of the 16 letters suggested the presence of organic disease as well. The problem of which patient the family doctor refers to a psychiatrist and which patients he should refer has recently been discussed by Kessel (1963). He comments that referral of neurotic patients should depend on clinical severity of the symptoms and failure to respond to treatment rather than niceties of diagnosis or length of history.

From the point of view of the specialist who sees these patients, his main function appears to be to exclude the presence of organic disease. Today diagnosis is the keyword in clinical medicine and diseases are being investigated by more and more elaborate techniques. It is very easy to forget the patient as a person with his own emotional and social problems among the technicalities of modern medicine in a busy out-patient setting.

The implications of this sort of study are that the family doctor and specialist should be able to recognize, investigate and treat these patients with relatively mild psychiatric illnesses. It is particularly important that undergraduates should not learn from specialists to be unsympathetic to psychiatric patients and their symptoms.

The Cornell Medical Index Health Questionnaire: (C.M.I.)

The clinical investigation described above was an appropriate setting in which to test the value of the above medical questionnaire. As the results showed that the questionnaire is a useful tool in detecting the neurotic patient, its use will be described, though a full statistical analysis of the results has been published elsewhere—(Culpan, Davies and Oppenheim, 1960).

The C.M.I. is a four-page self-administered inventory of 195 questions. These questions are phrased in informal language and to each question the patient answers 'Yes' or 'No'. The questions correspond closely to those usually asked at a comprehensive medical interview. There are two forms of the questionnaire, one for women, one for men, identical except for six questions on genito-urinary symptoms. The development of the C.M.I. is described by Brodman, Erdman, Large, Wolff and Broadbent (1949). It was

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intended to obtain the facts of a medical history and to serve as an adjunct to the interview. The questionnaire is divided into 18 sections. The first 12 sections deal with individual bodily symptoms; e.g. respiratory systems, digestive tract, skin, etc. The last six sections deal with mood and feeling patterns. With a completed questionnaire a cardiologist, for example, need not ask unnecessary questions about the nervous system or skin unless the answers indicate positive symptoms in this field. Similarly, a psychiatrist need not enquire into bodily symptoms if the answers to these questions on the questionnaire show that no symptoms are complained of.

The questionnaire takes patients 10 to 20 minutes to complete and as a rule, they find it a welcome task while waiting for the doctor. The completed forms can be 'read' very rapidly and 'Yes' responses noted.

In the present investigation all patients seen completed the questionnaire and the scores were compared statistically with scores obtained from a group of 104 psychiatric patients at the Maudsley Hospital and a group of 118 normal controls working at a large London store. Total 'Yes' responses to the questionnaire or to a particular section or sections of the questionnaire can be used in the statistical evaluation of the scores. Women record more 'Yes' responses than men so that the sexes have to be assessed separately for statistical purposes.

Table 5 shows the total scores and number of subjects in the neurotic and normal control groups, and the patients at the medical out-patient clinics separated on clinical grounds into 'organic' and 'psychiatric'. It will be seen that the control groups show a highly significant difference in the number of 'Yes' responses made to the questionnaire. The 'normal' women give on average 21 'Yes' responses as compared with the 'neurotic' women's 46.

Similar significant differences were seen at the medical clinic when the organic and psychiatric groups were compared, the latter giving twice as many 'Yes' responses as the former.

These findings confirm the previous reports on the Cornell Medical Index and despite a clinical bias against such questionnaires, it might prove of value in detecting psychiatric patients in general practice or at the general hospital clinics.

Conclusion

Psychiatric illness presents diagnostic and therapeutic problems at general hospital clinics. These illnesses and the problems they present deserve further consideration by family doctors and specialists.

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