MEDICAL PRACTICE

*For Debate . . .***Consultant physician to outpatients**

JOHN W TODD

British Medical Journal, 1978, 1, 417-420**Summary and conclusions**

Analysis of the records of the last 450 outpatients referred to me showed that the basic disorder of at least one in three lay in the psyche, and there was a large emotional element in many of the others. None were put on a waiting list for admission. Not only should physicians be generalists most of the time (whether or not they have a special interest) but most medical problems are best dealt with by the GP. Only occasionally can the physician attach a precise diagnosis to a patient who has been an obscure problem to his GP, and the physician's most important function is to reassure the patient and explain his symptoms. Routine investigations seldom benefit the patient.

If there could be a more equitable distribution of GPs of high quality with good back-up facilities fewer general and many fewer specialist physicians would be needed.

Introduction

In January 1944 I analysed the records of 500 consecutive soldiers who had been referred, by their regimental medical officers, to me at the outpatient department of a military hospital in Britain.¹ Of these 146 (29%) were frankly psychoneurotic, many with the "effort syndrome"; 95 (19%) had mainly dyspeptic symptoms; and 60 (12%) some kind of "rheumatism" (there seemed to be a large emotional element in most of these too). One hundred appeared to suffer from chronic bronchitis, though the main reason for their attendance seemed to lie in their mental rather than their physical state. I virtually never admitted these soldiers to hospital.

Although there are big differences between the patients referred to civilian hospitals now and those referred to military hospitals during the war, there are many similarities. In this article I analyse 450 consecutive cases referred to me during 1976-7, at the end of my consultant career. I shall then consider what is the proper function of the consultant physician to outpatients.

Classification of patients

Of these 450 patients, sixty (13%) were diabetics; seventy patients (15%) complained mainly of chest symptoms, including pain, palpitation, and breathlessness; twenty of these had pain probably related to coronary artery disease, and in 33 there was no evidence of appreciable heart or other disease, and there seemed to be a large emotional element. Sixty-seven patients (15%) had mainly abdominal symptoms, in 23 of whom the predominant basis appeared to be emotional. Twenty patients (4%) complained most of such head symptoms as pain, unsteadiness, and muzziness, and in 16 of these the emotional state seemed largely responsible. Twenty-five patients (6%) had "rheumatic" and back problems, but in only six did the main basis appear to be emotional. The most important reason behind the referral of 15 patients (3%) was obesity, and 11 of these seemed emotionally disturbed. Sixteen patients (3%) were referred mainly because of hypertension and many of them had—at least before the discovery of their hypertension—no symptoms connected with the blood pressure. Nine patients (2%) had malignant disease. Sixty-one patients (13%) had multiple somatic symptoms or a general feeling of malaise, or both, and various overtly psychological symptoms. In all the psyche appeared largely responsible.

Thus among the 450 patients the predominant trouble of at least 150 (33%) seemed to be emotional, and among the remainder there was often a large emotional element. Many of those with hypertension and coronary artery disease were worried and had associated psychosomatic symptoms.

Disposal and investigation

I admitted four patients immediately. One had diabetic gangrene; one had the Guillain-Barré syndrome; one had had a subarachnoid

Farnham, Surrey

JOHN W TODD, MD, FRCP, retired general physician

haemorrhage the previous day; and one was a gross hysteric who repeatedly fell out of her chair in the waiting area and bruised herself. I arranged to admit a patient with papilloedema to Atkinson Morley's Hospital.

I admitted none of the remaining patients. Ever since I decided not to admit soldiers from outpatients during the war I have maintained² that there is very rarely justification for placing medical outpatients on a waiting list for admission to a medical ward, either for investigation or for treatment. All the appropriate investigations could be done with at most a spell in the day bed unit, and few needed that.

I did no investigations (beyond an electrocardiogram (ECG) in some cases) in no fewer than 70% of patients. Most of these had already been investigated by their GPs, and I could see no ground for doing more. There were no routine investigations. Yet in some of the most celebrated institutions many investigations are done as routine. Those who do this would do well to analyse their results. Korvin and others³ analysed the records of 1000 patients who had each had 20 chemical and haematological tests. Although 2200 results were deemed abnormal and yielded 83 new diagnoses, none unequivocally benefited the patient. The solitary patient who might have benefited was one who was thought possibly susceptible to liver damage from halothane anaesthesia, and even this was uncertain. Possible benefit to one person from 20 000 tests is—in the authors' words—"not impressive."

Especially among patients with longstanding symptoms by far the most important diagnostic procedure was the history taking. The patient who complains that he has been ill for years or "all my life" with tiredness, headache, backache, "indigestion," etc may be found by unwise investigations to have an abnormal ECG, narrowed lumbar disc spaces, opaque cranial air sinuses, or a hiatus hernia, but these can bear little if any relation to the symptoms.

Psychosomatic symptoms

In my student days and later it was often said that before a patient is decreed neurotic every possibility of organic disease must be excluded. This view is still heard today. This doctrine is absurd and implies that if organic disease is found the patient cannot be neurotic. There should always be positive grounds for saying that a patient is neurotic or has psychosomatic symptoms.

The reason why I concluded that the symptoms of about one-third of my outpatients were largely or wholly emotional was derived from the nature, number, and duration of the symptoms. Certain somatic symptoms immediately suggest an emotional origin. The most obvious is weeping. Others are impotence, dyspareunia, longstanding general weakness or feeling "always tired," palpitation, trembling, persistent head sensations (such as pressure, bursting, muzziness, or a "tight band"), persistent aching in the chest, continuous low backache, and continuous belly sensations. Patients with these symptoms are often overtly depressed or anxious, with perhaps a history of "nervous breakdowns."

The deduction that symptoms are psychosomatic does not prove that a patient must be free of organic disease, and it may therefore sometimes be right to investigate him. If someone has had unvarying symptoms for years anything found by investigation is unlikely to be relevant. On the other hand, if a longstanding neurotic patient has recently developed fresh symptoms investigations may be justified.

The investigation of neurotic patients is sometimes defended on the ground that this is needed to reassure them that they are free of organic disease. This is a most doubtful argument, though occasionally it may be proper to do a particular investigation for this reason. Moreover, the statement that some investigation proves that some disease is absent is usually false. If a patient who is worried about his heart is told, "the ECG proves your heart is normal," he is being told a lie, though it might well be claimed to be a justified lie.

General physician or specialist?

Throughout my medical career there has been an endless debate whether physicians should attempt to cover the whole field of medicine or confine their attention to some system. It has many times been said that the complexity of medicine has made the old-time general physician obsolete. *The Times* obituary of Lord Cohen of Birkenhead⁴ commented, "In an era when the end of the general physician was constantly being forecast his intellectual capacity and astonishing memory gave

the lie to this." But—leaving aside neurologists, dermatologists, chest physicians, and rheumatologists—physicians in Britain have in fact continued to act as general physicians to this day, whether they consider themselves to be cardiologists, gastroenterologists, nephrologists, or endocrinologists. For their inpatients admitted as emergencies—and nearly all occupants of an acute medical ward should be emergencies—are admitted under each physician on specified days, so they all have the usual mix of patients with chest-pain problems, overdoses, strokes, bronchitis, etc. And in the outpatient department physicians are referred all manner of problems.

Would it be desirable to end the present system and attempt to ensure that all heart patients were under the care of cardiologists and all those with alimentary upsets were under the care of gastroenterologists? One obvious difficulty is that there is often doubt as to which system is at fault, this doubt being the very reason why the GP referred the patient. And if the general physician disappears and the GP wishes for a second opinion on someone who complains of feeling generally ill with widespread pain what does he do? Many medical outpatients are predominantly psychological problems, and the GP is usually aware of this but wishes to be reassured that the patient is free of important organic disease. Or the patient may fear that he has some unpleasant disease and the GP hopes the consultant may be able to convince the patient that his fears are groundless.

For most patients the "ever increasing complexity of modern medicine" has no relevance. For only a microscopic proportion of all the people who see their GPs, and a very small proportion of those referred to medical outpatient departments, is advanced technology appropriate. Certainly, many are in practice subjected to various investigations, and some physicians do routine investigations on everyone. Which physician is most likely to make a balanced judgment here—he who considers himself to be a general physician or he who confines, or would like to confine, his entire attention to one system? I suggest that the general physician would win.

An increasingly used advanced technology investigation is coronary arteriography. The one convincing justification for this is the presence of severe symptoms due to myocardial ischaemia, which cannot be relieved by weight reduction, beta-blockers, and trinitrin in a patient suitable for a coronary bypass procedure. In the two years before retirement I saw no such patient, yet in some hospitals many patients have coronary arteriographies. It has been said recently that because the ECG gives so little information about the state of the coronary arteries most patients with obscure chest pain should have a coronary arteriography. This is monstrous. The only justification for investigation, especially if risky and expensive, is to benefit the patient. In any case the discovery that a patient with obscure chest pain has diseased coronary arteries does not prove the pain must be due to myocardial ischaemia. Those who advise this unjustified procedure are usually cardiologists, not general physicians.

A few years ago the ECG was more overvalued as an indicator of coronary artery disease than it is now. William Evans⁵ stated, "When the ECG is normal it excludes a diagnosis of cardiac infarction." And Paul Wood⁶ wrote, "The diagnosis of acute cardiac infarction is practically untenable if serial ECGs remain normal in all the recognised leads." Both men were eminent cardiologists. Yet this assertion is not made today. And it was certainly obvious to me that "a normal ECG cannot exclude infarction." For one is never justified in asserting that any investigation is infallible unless it can be compared with another observation, which is itself infallible. Clearly, there was no such other infallible guide to the coronary circulation.

One of the worst errors made by doctors has been the wrong attribution of symptoms to disease—actual or hypothetical—of the system from which the symptoms arose. Belly symptoms were attributed to visceroptosis, chronic appendicitis, hyperchlorhydria, chronic gastritis, or—more recently—hiatus hernia. Such cardiac symptoms as palpitation, left mammary aching, and sighing respiration, along with sweating and tremb-

ling, were attributed to primary cardiac overstrain or myocarditis. Backache was attributed to retroverted uterus, and headache to errors of refraction, sinusitis, cervical spondylopathy, or hypertension. The specialists who concentrate their whole attention on their own region are particularly apt to make such errors. A patient with headache may be referred in turn to an ophthalmologist who diagnoses an error of refraction, an ENT surgeon who diagnoses sinusitis, and a rheumatologist who diagnoses cervical spondylopathy.

In an article on specialisation* I concluded that the main justification for specialisation among clinicians is the mastery of difficult techniques. Therefore there should be orthopaedic surgeons, neurosurgeons, thoracic surgeons, etc. But this has far less relevance to physicians, most of whom, whether specialists or not, do not master any difficult techniques. Moreover, the justification for doing most advanced technical procedures, such as cardiac catheterisation or aortography, is the possibility that these will determine whether an operation will help. If there is no prospect of operation, performing these procedures is mischievous interference.

In 1951 I wrote, "The value of the physician is derived far more from what may be called his general qualities than from his special knowledge. . . . Such qualities as good judgment, the ability to see the patient as a whole, the ability to see all aspects of a problem in the right perspective, and the ability to weigh up evidence are far more important than detailed knowledge of some rare syndrome."⁸ The passage of 26 years has not changed my views. Moreover, all clinicians should be generalists much of the time. When the abdominal surgeon is performing a gastrectomy he is acting as a specialist because of the need to master a technique. But when he is assessing a patient before deciding whether to recommend operation he should be a generalist. The cardiologist who, following the advice of an eminent practitioner in this field, makes "the ECG the final arbiter," the ENT surgeon who sees patients only in a dark room while transilluminating their sinuses, or the gynaecologist who looks at patients only through a vaginal speculum are all bound to make disastrous errors.

Function of the consultant physician

The traditional function of the physician was to make a diagnosis, though in view of the lack of effective treatment this rarely helped the patient. As a student I used to hear stories of the giants of the previous generation who would be called to an obscurely ill patient who had baffled both the GP and lesser lights in the hospital and would rapidly pronounce the diagnosis, which invariably turned out to be correct. In obituary notices we still read of the great diagnostic prowess of physicians. It was said in *The Times* that Sir Arthur Thomson had "the capacity to solve a diagnostic problem which had defeated all others."⁹

The very idea that the Great Man can solve diagnostic problems by examining the same data that have defeated others is usually absurd. An obscure problem to one physician is an obscure problem to others. Occasionally, it is true, someone may be able to think of a diagnosis—perhaps because of experience of a similar case—that others have not thought of. But even then he can rarely make a confident diagnosis: he can merely suggest further tests that may prove or disprove the new hypothesis.

Diagnosis is not an end in itself, but a means to the end of helping the patient. The question I asked myself when seeing an obscurely ill patient was, "Is there any possibility that he has a condition for which there is effective treatment?" But among my last 450 outpatients there was only one such patient—a man with metastatic prostatic carcinoma. In other cases I was able, perhaps after doing investigations, to reach a diagnosis, though this did the patient no good. When a patient was evidently very unwell physically and getting worse a likely guess, especially if he was a heavy smoker, was metastatic bronchial carcinoma, even if the chest x-ray result was normal.

Some obscurely ill patients, when there was no reason to say that emotional factors were playing a large part, recovered without being diagnosed. I had no difficulty in saying that I did not know what had been the matter, but many physicians are apparently most reluctant to say, "I do not know." This is unfortunate, and in the long run the pretence of omniscience does not impress the good GPs.

There is a widespread belief that if one is clever enough and learned enough all patients can be fitted into a neat pigeon-hole called an entity. But there is no reason to believe this is true. Entities are invented by man; Nature is not so simple. This difficulty especially occurs with the rheumatic conditions. We read that there are, say, over 200 different rheumatic diseases, but this kind of statement seems meaningless. A patient bed-ridden with polyarthritis that has ankylosed many joints and a patient with minor swelling of two proximal interphalangeal joints are, to ordinary observation, entirely different, yet both are said to have the same entity—rheumatoid arthritis. Whereas a third patient with severely affected limb joints that appear just the same as the first patient, but who also has spinal disease, is said to have the different entity—ankylosing spondylitis. Particularly with endocrine conditions it is difficult to draw a line between normal and the disorder. If an obese diabetic restricts his diet all evidence of diabetes may disappear, even his glucose tolerance test becoming normal. Is he then still a diabetic? Or is he an ex-diabetic or a potential diabetic? No clear answer can be given to such questions.

The very idea that diagnosis solely consists in attaching a label to a patient is, in any case, false. When dealing with acute conditions attaching the correct label may be most important. Diagnosing enteritis when a patient has a gangrenous appendix is disastrous. But the longer the history and the greater the number of symptoms the less relevant is the single diagnostic label. And patients with long histories and multiple symptoms are the typical attenders at medical outpatient departments. The malaise of the patient with coronary artery disease, chronic bronchitis, or peripheral arterial disease is not just determined by the state of his heart, chest, or arteries: it is also determined by his psyche, and that in turn is related to his temperament, his job, his wife, and his circumstances. The severity of pain is determined both by the state of the part from which the pain arises and by the psyche. Chronically complaining patients, therefore, should be diagnosed not by a word but by a sentence, such as: "Habitually worrying man with a boring job and a nagging wife who has myocardial ischaemia not interfering with his ordinary activities, but about which he is very worried."

ADVISING ABOUT TREATMENT

Some patients, especially diabetics, the obese, and many hypertensives, are referred for help with treatment. Otherwise I was reluctant to give detailed advice about treatment to GPs, or to give advice direct to the patients. For if a change in treatment is advocated this usually implies that the GP has been mistaken in his previous handling of the situation, and a consultant should be sure of his ground before recommending such a change.

There are nevertheless certain pieces of advice that can rightly be given direct to the patient—advice which he has usually already been given by his GP. "Eat less: stop smoking" is an example, although it is rarely observed. I regularly gave patients encouraging advice. Except when dealing with the obese, "Eat what you like and do anything you like that doesn't distress you" were favourite recommendations. And I never recall advising a patient to change his job; I merely said sometimes that if he feels his job is beyond him it is only reasonable to find another job that he can manage.

When I did suggest to a GP that treatment should be changed, this change was often that a drug should be omitted. This was notably so when elderly people were having hypotensive drugs, methyl dopa in particular, which had sometimes caused unpleasant side effects. I also suggested that anorectic drugs,

thyroxin (when used in treating the obese), and so called vasodilators—perhaps the most useless group in medicine—should be stopped, and that iron by mouth is nearly always as effective as iron by injection. I often expressed doubt about psychotropic drugs and suggested that cheap analgesics such as aspirin may be as effective as and no more risky than vastly more expensive preparations. And I advised that obese maturity-onset diabetics should stop taking sulphonylurea compounds.

REASSURANCE

In at least one-third of my outpatients the psyche appeared to be largely or wholly responsible for the symptoms—and in many of the others it played a large part. We all know that when depressed and anxious, symptoms are worse than when one is elated. Worrying about symptoms—or about what is feared to be causing them—makes them worse. All clinical consultants, as well as GPs, should try to improve their patients' state of mind. How much help can be given by reassurance, explanation, and encouragement?

No firm answer can be given to this question. But, speaking as a lifelong sceptic about treatment, I have no doubt that help can be given to some patients by simple psychotherapy. The most promising subjects are those who have recently become worried about the disease they know or fear they have. Someone who is told his blood pressure is raised may have bursting sensations in the head that he takes for granted are caused by his blood pressure and fears presage a stroke. A categorical promise that blood pressure does not cause such symptoms may give great relief. A man with aching in the chest, palpitation, etc., may fear heart disease. An explanation that symptoms of this kind are never caused by disease of the heart and that—as we all know—emotion causes palpitation, sweating, shaking, and faintness may rid him of his fear. The man who has had a cardiac infarct is unduly liable to have cardiac anxiety symptoms, which he naturally attributes to the diseased state of his heart. If he is promised that his heart has recovered well and it is explained that these symptoms are due to his natural anxiety he may be most relieved.

Anecdotal evidence is not worth much. But over the years I have seen many patients who, when returning for a second visit after this simple psychotherapy, have been much better and most grateful. Often I have been told that their initial main symptom has gone completely. Some have said "I'm wasting your time; I'm now quite better."

RESEARCH

The most prestigious medical research is that which it is hoped will result in the cure or prevention of disease. Nearly all such research is carried out by backroom scientists. Clinicians become concerned only when the backroom scientists produce a new drug that they wish to be tried on man.

The type of research that clinicians can do is the observation and investigations of groups of patients in the hope of learning more about the nature of maladies. Over the years much has been learnt by this type of study. Provided a patient is neither harmed nor inconvenienced, this seems fully justified, and the average patient is quite willing to be studied just for the sake of humanity.

This kind of observational research can nevertheless be misleading when dealing with variable longstanding maladies. For the most severely affected are most likely to be referred, whereas the most slightly affected may not even see their GPs. Those who work in hospitals gain the impression that peptic ulcer, colitis, rheumatoid arthritis, multiple sclerosis, etc., are much worse than they are. It used to be said that in the end multiple sclerosis is always fatal. The reason for this depressing conclusion evidently was that the minor cases with lifelong remissions were not

seen by the eminent neurologists who wrote the textbooks. Moreover, the organisations that represent the victims of these maladies naturally emphasise their worst aspects. The public are not asked to subscribe money for research into multiple sclerosis that caused one attack of retrobulbar neuritis or into rheumatoid arthritis that affects one finger joint. The appeal is on behalf of those helpless from multiple sclerosis or crippled with arthritis.

GPs can also do useful observational research. If a GP is working in an area with a stable population he can advance knowledge a great deal. In particular, a 30-year-follow-up of his patients with peptic ulcer, rheumatoid arthritis, etc., would greatly improve our understanding of these maladies.

Discussion

Apart from giving guidance to diabetics, the obese, hypertensives, etc., the main benefit that I felt able to give outpatients was reassurance. The traditional function of the consultant physician—to diagnose a bodily disease in the obscurely ill person—seemed in practice of little importance, since only very rarely did this result in benefit to the patient. On the other hand, when patients were known to have organic disease I was often able to point out that most of their malaise had its origin in the psyche rather than the soma.

Among all the mistaken ideas of today, one of the most absurd is that because of the ever-increasing complexity of medicine the day of the generalist is over. Not only should physicians be generalists most of the time (whether or not they have a special interest) but most medical problems are best dealt with by the general practitioner. If in future we can have a more equitable distribution of GPs of high quality with good back-up facilities, and possibly an increase in their total number, we shall be able to do with fewer consultant physicians, and many fewer geriatricians and psychiatrists. Yet many specialist physicians claim that their numbers should be increased. Rheumatologists emphasise that rheumatic complaints are very common but few of their victims see a rheumatologist. What we need is a cure for rheumatoid arthritis, not the multiplication of rheumatologists. And this cure will be discovered, if it ever is, by the backroom scientists.

The specialist is genuinely needed when his work includes the mastery of techniques. We therefore need surgeons who deal with specific areas, since no surgeon can be an expert in the operations affecting all parts of the body. But surgeons too should be generalists much of the time, especially when dealing with chronic complainers in outpatient departments.

References

- 1 Todd, J W, *British Medical Journal*, 1944, **1**, 19.
- 2 Todd, J W, *Lancet*, 1973, **1**, 1106.
- 3 Korvin, C C, et al, *Annals of Internal Medicine*, 1975, **83**, 197.
- 4 *The Times*, 9 August 1977.
- 5 Evans, W, *British Medical Journal*, 1959, **1**, 249.
- 6 Wood, P, *Diseases of the Heart and Circulation*. London, Eyre and Spottiswoode, 1968.
- 7 Todd, J W, *Lancet*, 1959, **1**, 845.
- 8 Todd, J W, *Lancet*, 1951, **1**, 462.
- 9 *The Times*, 16 July 1977.

(Accepted 13 December 1977)

What common symptoms of anxiety are often much relieved by beta-blockers? Do these drugs also relieve dry mouth in an anxious person?

The greatest effects of beta-adrenergic blocking agents in patients with anxiety states are reduced heart rate and tremor. Dryness of the mouth is unaffected as they probably act by inhibiting parasympathetic activity.