The Linacre Quarterly

Volume 37 | Number 1 Article 28

February 1970

Medical Practice as It is Seen by Psychologists, Hospital Chaplains and Psychiatrists

Samuel B. Hadden

Medical Practice as it is Seen by Psychologists, Hospital Chaplains and Psychiatrists

Samuel B. Hadden, M.D., F.A.C.P.

Computerized medicine is on its way. It will not be long before one's medical record, from birth to death, can be recorded and computerized in a central national agency. Subsequently whenever one is admitted to a hospital their Social Security Number can be tapped out on a machine and in minutes a resume of their previous medical findings will be received and made a part of the Hospital Record. Notations from each hospitalization will be added and the centrally recorded data will be a continuous record of medical history and findings of each person.

Soon in major medical centers a patient's history and examination can be tabulated and fed into a compu ter and in minutes a tentative diagn osis along with suggestions for des red laboratory studies and treatm ent procedures will be produced by the computer.

Already we have sophistic ted machines that receive a blood sam ple from which, without human in ter-vention, an ever increasing numbe r of chemical determinations can be m ade with reasonable accuracy. In kee ping with these advances many change s in teaching in our medical schools ca n be anticipated. Teaching machines are being employed more and more a d it is not inconceivable that their u se in colleges and high schools may pre pare students more rapidly for admissio n to advanced standing in medical sch ools and even in specialty training cen ters.

With such advances the care o f the sick person becomes more and more depersonalized and, as more sop histi-cated automatic equipment is de-veloped, it is conceivable that a pa tient may be run through the computer ized machinery of a hospital and have a diagnosis and program of treatment outlined for him without ever having any contact with a physician. Even a program of after care may be pre-sented to the departing patient along with the bill for "computer time" utilized during the passage through the production line of the establishment.

While such "Medical Care" may lie some time in the future there is little doubt that personalized care and in-dividual study of a patient's illness is already diminishing. With the advent of Penicillin it initially was a joke, but almost a reality, that it was routine to immediately give all patients admitted with an elevation of temperature anti-biotics, and if the elevation of temper-ature was not reduced to normal within forty-eight hours it was manda-tory that they be examined to see what was wrong.

Laboratory studies of all types have made more accurate diagnoses possible and enable us to follow the progress of a disorder more carefully. However, the growing dependence of the younger physician upon laboratory studies is at times surprising. A few years ago a medical resident was amazed that I made a correct bedside diagnosis of Myasthenia Gravis without a blood phosphotase level.

As our medical schools become pre-occupied with laboratory diagnostic methods, the student is less well pre-pared to obtain valuable information and knowledge from study and ob-servation of the patient. Since our hospitals are caring for an ever smaller percentage of really sick people and greater numbers are admitted for diagnostic studies, emphasis has shifted from the care of the sick person the accuracy of diagnosis bolstered by an ever increasing volume of laboratory and diagnostic studies. Interns and residents spend more and more time in conferences and classes so that they have less and less time to spend with patients and become acquainted with their emotional problems.

The movement toward full time staff physicians and fewer private practicing physicians on a hospital staff makes it difficult for the patient to obtain adequate follow through care. After discharge, if new symptoms or aggravation of old symptoms occurs, the patient is often advised to return to the hospital for care to be supervised by the full time staff member. Such practice leads to over-utilization of hospital beds and, with each readmission, additional labora-tory studies add to the rising cost of health care. Physicians trained in such a setting are poorly prepared to provide adequate personalized care as family physicians, and as a result patient dissatisfaction with health care is on the increase.

It is well to recall that hospitals came into existence near centers to which worshippers made religious pilgrimages. Initially the priests of the temples provided personal services to the afflicted and in these centers knowledge of disease accummulated. Soon physicians became attached to the temples, and from these centers knowledge of the nature and course of disease was disseminated. Eventually the priests delegated the treatment of the pilgrims' illness to those most skilled physicians, while the priests assumed their spiritual guidance. Today our hospital chaplain is often the one most involved in the care of the sick person, while the medical staff

Dr. Hadden graduated from the University of Pennsylvania Medical School in 1924. After training at Philadelphia General Hospital he began a career in private practice and teaching. He was recently made Emeritus Associate Professor of Psychiatry at his Alma Mater.

A pioneer in the development of group psychotherapy, Dr. Hadden is a former President of the American Group Psychotherapy Association.

devotes time to the conquest of his disease.

Because the mentally afflicted sought help in the developing medical centers attached to religious centers it was natural that a "Demoniacal theory" of mental illness came into vogue. If the symptoms of the mentally ill were benign they were regarded as being possessed by good spirits and they were respected and often revered. If their symptoms were objectionable they were thought to be possessed of evil spirits which must be exorcised by harsh and even brutal methods.

At times it seems that some of this ancient classification of disorders still prevails. Those patients whose disorders are easily influenced by therapeutic measures are appreciated by students, interns, residents and staff alike because they respond to their magic. Even the obviously hopeless cases are at times regarded favorably because they make no demand on the physician, but those whose illness is regarded as not based on demonstrable organic disease and are considered to be neurotic are irritants to many doctors. They are often scolded and told there is nothing wrong with them and it is up to them to snap out of it and get well. Little attention is paid to the problems within their lives to which they are reacting with symptoms on which they focus their attention. By converting their worries into physical symptoms they seek the attention which they have equated with love ever since childhood. While it is not good medicine to provide this secondary gain of illness by coddling the patient and giving them a variety of tranquilizers and medicaments, it is essential that they be given the opportunity to discuss problems that activate anxiety and other strong emotions.

I often recall experiences with students in group sessions which were conducted with the objective of trying to help them appreciate their own emotional response to patients and to help them understand that as physicians they should be the most effective therapeutic agent that could be brought to a patient's bedside. Our sessions followed their attendance in the medical outpatient department and as they assembled before we began our sessions they discussed the cases they had been assigned in the medical clinic.

One day a student was thrilled at seeing a new patient who was jaundiced and found to have a large nodular liver. The history and findings made the diagnosis of metastatic carcinoma of the stomach most likely. With this definite diagnosis the student felt that nothing more could be expected of him. The disease was untreatable and he felt absolved from all responsibility, so he had little concern for the patient. The same day another student described his patient as a "whining, 55 year old female crock." This was an unacceptable and objectionable patient who made the student and the dispensary supervisor uncomfortable. The patient was wanted and needed something more than a pill from the physician and because she complained of their inability to relieve her after many visits she was finally sent to the psychiatric department. She had exhausted the patience of the specialists in the clinic to which she had been referred for study and treatment.

In the general hospital today the "crocks," and those who make a demand upon the physician for consideration are often referred to the psychiatrist or the chaplain.

Patients who are annoying or troublesome are not popular in the average general hospital. In fact, in many hospitals they are not admitted. In one hospital in which I served, the administration would not consider the admission of alcoholics and selected psychiatric patients for care unless they had a private room with private nurses around the clock. This concession was seldom if ever utilized by the staff and not until almost every hospital in the area had provisions for the proper care of selected psychiatric patients did the administration give consideration to a psychiatric section or the admission of patients with selected mild psychiatric disorders.

With the development of community health centers, hospitals will undergo changes in response to the alteration of their case load and more attention will be given to preventive medicine, and gradually preventive psychiatry will come to the fore.

It must be realized that whenever a patient who is truly sick enters a hospital he becomes, to some degree, mentally disturbed. He becomes concerned about paying his bill, about the outcome of his illness, about the welfare of his family and many other facets of his life. Such anxiety may produce a group of symptoms that puzzling to the physician. In the modern hospital few full-time physicians are concerned with the personal aspects of the patient, and their state of concern is often neglected.

In the general hospital a generation ago these persons were usually admitted to the hospital under the charge of their own private physician who, as a rule, was concerned about his patient's needs during the stay in the hospital as well as after his discharge. Those without specific organic disease were very often sympathetically treated with placebos, and dependence upon the physician provided them with so much secondary gain that a degree of invalidism was embraced and too frequently prolonged into a way of life. Psychiatric referral of the anxiety states and the psychosomatic disorders was not a particularly common procedure a generation ago, and it was not uncommon to see patients who were informed that if they didn't snap out of it and forget their symptoms that were not on an organic basis they would wind up in the hands of a psychiatrist. The psychiatrist was used as a threat.

Ward patients who did not have a private physician were usually referred to the medical out-patient department at the time of discharge. If they failed to respond to the administrations of the specialist in the out-patient department to which they were referred they were dispatched to other clinics for consultation, but almost invariably they were sent to the neuropsychiatric department only when they had exhausted the patience of the physicians in the various medical and surgical clinics. The psychiatric clinic was the end of the line.

Because of this tendency the patient-load in neuropsychiatric out-patient departments increased steadily. There was not sufficient staff or time available for meaningful psychotherapy on an individual basis and it was because of this that I personally began to use a group approach to those patients whose illness was on an emotional basis in early 1937 at Presbyterian Hospital in Philadelphia.[3] It was initiated as an expedient measure without any awareness that it had previously been used by anyone.

It is interesting to note that the same technique began to be used in many clinics about the same time, and with the onset of World War II group psychotherapy quickly became a very meaningful technique in the armed forces of all combatant nations. Now there are few hospitals in which group psychotherapy is not available.

Today, in most hospitals, the services of the psychiatrist are employed more freely than ever before. Most physicians now recognize the symptoms of an anxiety state and seek the assistance of the psychiatrist. In many instances where the psychiatrist or the managing physician feel the patient is in need of spiritual assistance the hospital chaplain or the patient's own clergyman is called upon to render help. The psychiatrist and the chaplain now work together with many patients and it is becoming more common for the clergyman to recognize the need for psychiatric services to those who seek his counsel. Fortunate is the hospital that has chaplains and psychiatrists who recognize their limitations and work co-operatively in the interest of better care of the sick.

In this time of increasing emphasis on the prevention of illness the services of the psychiatrist can and should be utilized on a wider scale than is generally recognized. For instance, in no place can psychiatric services be more valuable in preventing emotional disturbance than in the prenatal clinic and in obstetrical practice. A brief experience in a prenatal clinic will amaze one when expectant mothers begin to express their fears and reveal their misconceptions about the dangers of having a child. Imagine the concern of the expectant mother who looked forward to becoming a mother but when she is pregnant t ins to worry about the great responsibility of bearing a ch ld, until she cannot sleep, and dur ng most of her waking hours is p re-occupied with the fears of bein a poor mother. In a group of nine or en mothers she may find others who h ve the same fears and through free lis-cussion the therapist can be reassu ng and help them to discover the exp ri-ences or comments which caused th m to build up those fears.

The working through of host ity toward husbands in such ther py sessions has also contributed to re-serving the stability of many home: In the post-natal clinics those mot ers afforded the opportunity of discus ing their emotional problems nd acquiring a better understanding of the emotional needs of their children will assuredly become happier mother of better-adjusted children. Throug an increased awareness of the import nce of the mother-child relations in the first two years of life I am certain hat much unnecessary fear, guilt, re: ent-ment and hostility and resu ant unhappiness and social maladjustm nts can be avoided.

Fortunately many pediatrician: are becoming increasingly aware tha in addition to their role in the prever tion of the infectious disorders they can play an even more important ro e in the prevention of psychiatric prob ems in later life. Psychiatric indoctrin tion of the pediatrician is now an esse ntial part of his training.

In the changing atmosphere o the general hospital and in the comm nity health centers the psychiatrist can, along with the chaplain, play a n increasingly important role. Not only can the psychosomatic disorder: be better handled in group psycho-therapeutic sessions, but a large variety of neurotic and psychotic disorders can be handled in groups.[4]

Those suffering from many chronic and incurable disorders such as epilepsy, asthma, emphysema and even cancer, can be benefitted through group psychotherapy, and in such sessions as well as those aimed at prevention, such as those in the prenatal clinics, the presence of the hospital chaplain or affiliated clergyman as co-therapist can make a substantial contribution to the welfare of the afflicted. One can readily appreciate that the psychiatrist and chaplain can collaborate in helping those facing the inevitability of death with greater peace and composure.

In group discussions designed to help those contemplating marriage the psychiatrist and chaplain should make an ideal team and where sex education in schools is under consideration the psychiatrist and clergyman should participate actively and make a vigorous effort to have parents join in group discussions prior to the introduction of sex instruction in the schools so that the children are not educated beyond the level of parents understanding. To inform children beyond the level of parent education may contribute to greater friction.

The role of the psychiatrist in the instruction of interns and residents is often neglected in training programs, and not until physicians become more aware of the therapeutic potential of their relationship with patients will medicine and physicians become as respected as was the physician in the era when, with practically no specific and few effective therapeutic measures, the personal interest and the confidence he inspired was often the difference between life and death.

As medicine becomes more and more concerned with keeping men from dying it seems to me that our clergy became far too pre-occupied only with keeping souls out of hell. I now believe that the psychiatrist, along with his fellow physicians and clergymen, must join in teaching men to live with diminished fears, less unreasonable guilt, hate and hostility. They must defend more valiantly those established verities against nihilistic materialism.

REFERENCES

1. Hadden, S.B. The Utilization of a Therapy Group in Teaching Psychotherapy. *American Jl. of Psychiatry* Vol. 103#5 Mar. 1947 P. 644-648.

2. A Group Method of Teaching Psychiatry to Medical Students *Int. Jl. Group Psychiatry* 5-270 1955.

3. Hadden, S.B., Treatment of Neuroses by Class Technique *Annals Int. Med.* Vol. 16# 1 Jan. 1942 P. 33-37.

4. Hadden, S.B. Group Psychiatry in a General Hospital Diseases of Nervous System Vo. XVIII #10, Oct. 1957.