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"I can't find anything wrong with him physically. See what you can find," said the physician to the psychiatrist. "It's all in her head. Give her some pills and tell her to return in three months," said the physician to the nurse. Familiar statements? Yes, increasingly familiar as the physician is confronted in his office or clinic with physical complaints masking a wide range of non-medical problems. What does he do? It would be convenient to say that he refers such problems to his mental health colleagues, but this is unrealistic and often impossible. Sometimes the physician himself does not recognize or will not admit the presence of a psychological problem. More frequently, perhaps, the patient will not face the real issue and persists in generating physical symptoms or in magnifying existing symptoms. And in most areas, even when physician and patient admit the psychological disturbance, mental health facilities are not available. What most physicians face is a situation where such facilities are either nonexistant or inadequate or very expensive. Either there are no mental health professionals available, or they work only with the severely disturbed, or their schedule is filled, or their fees are prohibitive. In such cases the physician may try to handle the problem himself and yet feel frustrated or confused or irritated because this is not what he was trained to do. It is the purpose of this article to explore some of the issues so as to help the physician see more clearly what he is doing and why he is doing it. Perhaps this clarification will serve to help him function with greater confidence and less anxiety in his treatment of all levels of the psychosomatic unit we call man.

From talking with physicians in various areas I have come to realize a growing frustration at the demands made upon their time by people who are not really "sick." Thus when I was asked to submit an article for this issue of the *Quarterly*, I felt that this topic might be of interest to the harried practitioner. The problem is not so acute in hospitals or medical centers where a psychiatric staff is available for consultation, yet even there the physician in charge has the task of interpreting the findings to the patient and of formulating a treatment program. Likewise in many of the specialties the frustration of having to cope with psychological problems is not so acute since the screening process and the referral system tend to eliminate the non-medical patients before they reach the specialist. From my informal survey it seems to be the general practitioner who is struggling with the real problem cases, and so it is primarily toward him that I am directing this article.

Some physicians have told me that they spend from half to two thirds of their time on non-medical problems. Perhaps this would not have been unusual back in the days of the "family doctor," but it seems excessive to us today. How so? What is so different today that makes such an investment of time seem excessive? First of all, we can see that medicine has developed in the direction of greater sophistication, higher standards, more effective techniques, and increasing specialization. Advances in medical and paramedical sciences have accelerated over the past few decades so that more and more advanced training is necessary for the medical specialities. There is no doubt that the average physician today is far better prepared technically than was his colleague of fifty years ago. But with the advances in medicine it seems that something has been lost. That something is the personal, the human element in the doctor-patient relationship. Contributing to this dehumanizing process are the pressures and demands of medical training as well as the pressures and demands of medical practice. I am not saying that the loss of the personal element in modern medicine is either absolute or universal, but I am not alone in seeing it as a prominent trend. To the extent that a given physician has been affected by this dehumanizing process, to that extent he will feel irritated, frustrated, or anxious at having to deal with non-medical problems. These are personal problems, human problems, sometimes only remotely related to medicine.

Another significant difference in our country today from fifty years ago is realted to the socio-cultural profile. There has been an accelerating shift from rural to urban centers. Our society has become mobile almost to the point of being rootless, with resultant anonymity and anxiety. At the same time there is unprecedented emphasis on the material, on the physical, on the enjoyment of life here and now. In such a society, the physician who cares for the physical well-being of the individual is assigned the role of high priest, arbiter, and ulti-

mate authority in matters pertaining to the common weal. It is quite clear that many who formerly sought out their minister or priest now come to their physician for counsel and advice. Whether this is due primarily to the prevalent materialism of our society or to the isolation of the religious leaders is not clear. We know, however, that for many whose existence is characteristically anonymous the physician's office is one of the few places where they can find acceptance or recognition as an individual.

Perhaps we can state the problem in the form of a question. Can the physician today avoid involving himself in the non-medical problems of his patients when they come to him for help? And if he can avoid these problems, should he? One obvious problem has to do with the limitations of time. Medical problems can usually be treated in a fraction of the time that it takes for non-medical problems. If the physician has four hours for his office calls, and if he allots ten minutes for each patient, he can see twenty-four patients in the time available. The mathematics of the situation is quite simple. The complications are quite complex, involving not only the needs of the patients but the needs of the physician himself. Given the limitations of time and energy, and given the seemingly endless demands on both, the physician must decide where to draw the line. At what point does he cease to function for the benefit of the patient? Or, put another way, at what point does he begin to function in a way that is detrimental to the patient? One problem, of course, is to decide what is beneficial and what is detrimental, and the resolution of this problem involves some definition of the scop of medical practice. Would it be more eficial to the patient if the physician pent twenty minutes instead of ten with him? Other thi gs being equal, the answer to this qu es-tion would usually be in the affir ia-tive. But other things are not eq al. Such a change in policy would inv lve either an increase in the numbe of hours spent in the office or a decr se in the number of patients seen. D es the physician have the energy, he stamina, to spend eight hours on of ice calls in addition to his other work If not, is the benefit to the patients een for an extended session proportio ate to the presumed detriment to t ose patients who now cannot be seen?

Another issue that has been rais d is that of competence. Some physic an feel that to involve themselves in the non-medical aspects of their pati nts' problems is to exceed the bound of their professional training. It is te pt-ing for anyone in a position of au ior-ity to "play God," acting as if he ere not only omniscient but omnipo ent, and one who is competent in one are may tend to extend the scop of bounds without justification. N w I am quite willing to admit the in por-tance of professional competence an the need to observe the general bo nd of one's competence. Thus, c erg should avoid giving legal advice an lawyers should avoid giving me dica advice. But sometimes the questi n o competence is confused with the issu of what I call "territoriality," an thi issue has more to do with p wer authority, and prerogatives than wit competence. Further, it is more co cerned with the well-being a nd/o status of the professional than wit the well-being of the client or pa tient Some professionals try to giv th impression that the limits or bound aries of a given area of competen ce ar clear and fixed. That is hardly the cas at present and it is unlikely to be th case in the future. Why this is so ma be seen from a case, not too unusua of a person seeing simultaneously five professionals: a lawyer, a dentist, a clergyman, a teacher, and a physician. Each one is dealing with the same person but under a different aspect. To argue for professional competence has merit, but the primary issue is always the well-being of the person. We emphasize competence not for itself but for the person with whom we are working. As regards the physician's involvement in the non-medical problems of his patients, perhaps a closer look at the situation may shed some light on the issues.

The doctor is the "one who knows." He is a person with special training in medical science and with special skills in applying that science to help an ailing organism cure itself. The patient is the "one who hurts." He is a person who is experiencing some pain and wants help. Now the focus of medical training is on the physiological aspect of the organism, from the biochemical through the sensori-motor functions. But it is a PERSON who comes for help, and the complexities of a person extend far beyond the relatively simple physiological functions. This is a psychosomatic unit with emotional, volitional, and cognitive functions interacting with and influencing the physiological. These interactions may baffle or bewilder one who has been trained in the factual approach of scientific medicine, but they are realities which must be considered in applying the science to a given individual.

The doctor-patient relationship generally begins with the patient making the first move. He makes an appointment and/or comes to the office to meet the doctor. This situation in itself is significant. The patient encounters the doctor on the doctor's grounds, a fact which in itself may arouse anxiety or activate the patient's defenses. What is new and different is often threatening to a person, and when the situation involves examination as well as exposure the threat is intensified. Further, the average patient approaches the doctor with mixed feelings. He is hopeful but apprehensive, and the apprehension may lead to a variety of irrational behaviors. For example, the patient may give an incomplete explanation or he may conceal the chief symptoms or he may present such an array of symptoms that the doctor has great difficulty getting at the real problem. In some cases the patient is looking for reassurance that all is well, as if there was a magical quality in the pronouncement itself that would effect a cure. The experience of painful symptoms generates sufficient anxiety to move the patient in the direction of the doctor's office, but anticipation of the consequences if an illness should be discovered generates a contrary anxiety which blocks or distorts communication.

For the emotionally distrubed patient, the so-called "normal" ambivalence is often complicated by secondary gains from the physical symptoms. These gains may range from a face-saving mask which enables the patient to avoid looking at the real issues to a means of getting attention or sympathy. The fact that a patient chooses a medical doctor instead of a psychotherapist, at least where psychotherapists are available, is significant in itself, but the physician does not know that at the time of the initial visit. At that time all he has to work with is the communication of the patient, non-verbal as well as verbal. Starting from the first impression of the patient, the physician should be alert to cues affecting all of his sense modalities. It is not only what a person says, but how he looks and sounds, how he makes you

feel, that is important. The patient's tone of voice, his mannerisms, the way he dresses: all contribute to the total impression, all have some meaning, and all say something about the patient. The sensitive physician will be able to interpret verbal communication by means of non-verbal cues, and as he becomes more adept at picking up these cues he will become increasingly able to decode hidden or double messages. It is precisely such subtlety that is lost in the impersonal, detached, "scientific" approach of modern medicine. The patient's mode of communication may be taxing and is often exasperating. We would like him to state his problem clearly and succinctly so that a diagnosis can be formulated and a treatment procedure initiated. If there is significant emotional disturbance underlying the physical symptoms, it may turn out that the real problem will be uncovered only through a process of elimination over a period of time. The physician may discover only by a process of trial and error that he was misinterpreting the patient's communication.

The difficulty in discovering and identifying an emotional problem is exceeded only by the subsequent difficulty in doing something about it. In a sense psychotherapy begins with the initial encounter between physician and patient. As I understand it, psychotherapy is essentially an interpersonal relationship involving mutual communication between therapist and patient with the purpose of helping the patient function more adequately. Thus, psychotherapy is not a single, clearly defined procedure, however esoteric the term may sound. It takes varying forms and varying degrees of intensity, according to differences in needs, personalities, and circumstances. The physician who supplements a physical procedure with a sign of interest in the patient as a person is practicing psychotherapy. Likewise the physician who adds to a prescription the suggestion that after a short time on this medication the patient will feel better. Often a simple reassurance will produce a marked change in attitude and eventually in symptomatology.

More difficult to handle are those cases in which there is no identifiable illness, despite an impressive array of symptoms. In such cases the physician may have the feeling that he is missing something. Perhaps the only thing he is missing is the significance of the symptoms to the patient. He can assume that somewhere in the pattern there is a message and a request for help. Perhaps the message is: "I am lonely. I want someone to take an interest in me." In another symptom pattern the physician might hear "I can't take the competition in the business world anymore. I want an excuse to make a graceful exit." Any physician can verify the fact that his office waiting room is increasingly populated by lonely people who use their physical symptoms as a means of establishing some personal contact. The appointment with their doctor becomes a permanent fixture in their life pattern. At least someone is interested in them. Often these are the persons who are enjoying the benefits of significant advances in medical science but who are suffering because medical science cannot provide them with meaning and purpose in life. And so they turn to the medical doctor as a person who bears some responsibility for the inadequacies of medical science and they expect him to provide a solution to what is really an insoluble problem. If the physician recognizes the problem for what it is, and admits the limitations of his approach, he can in many cases alleviate the patient's pain and help make his existence more tolerable.

Quite a different situation exists under the face-saving use of physical symptoms. When the pressures, demands, and responsibilities of adult life become too difficult to handle, some will develop a set of incapacitating symptoms which provide an excuse for retiring from the struggle with a minimum of shame or embarrassment. After all, no one could expect a sick man to keep up such a pace. The physician's function here is to substantiate the malady and to establish a treatment procedure which will insure the survival but not the improvement of the patient. It is important that the physician read this message accurately so as not to become too ambitious for the improvement of the patient. This type can be notoriously obstinate, uncooperative, and even hostile when their symptom structure is tampered with, and yet such patients continue to seek medical treatment. Should the physician confront such a patient with the game he is playing? Or should he go along with the game, thereby helping the patient make some adjustment to his world?

These and many similar cases are seen daily in general practice and in medical clinics. Diagnosis and treatment remain the primary procedures, but with non-medical problems these procedures become highly complex. What I see as necessary to cope with the greater complexity is a more personal approach, with increasing alertness and sensitivity to the affect of the patient. Psychotherapy as an interpersonal relationship is practiced in some form by all physicians, and I hope that these observations will help the physician see the implications of this relationship. I can and should be a valuable adjunct in medical practice instead of being the burden or tolerated evil. Gradually then the physician will be able to work around the defenses, to pick up the nuances, to decode the hidden messages, and so be able to help more effectively the hurting patients who come to him.