Author's Preface

From one-fourth to one-half of the more persistent illnesses we see in medical practice do not respond well to the medical model of diagnosis and treatment we employ. Doctors recognize that these include the common functional disorders with predominantly somatic symptoms as well as the nervous states and depressive reactions with emotional symptoms. Personal distress unrelated to the disease itself can also be a major factor in the intensity and disabling capacity of many organic diseases.

We are well trained to diagnose and treat organic disease. But the illnesses caused mostly by personal distress constitute a far greater problem for medical practice. Diagnosis is sometimes deferred indefinitely. Extended but futile or misleading workups are not uncommon. Or, the illnesses are correctly diagnosed, but the care is restricted to the naming and treatment of symptoms. There may be little attempt to understand the underlying human problem situation. The illness persists or recurs because its source remains unattended.

This book (1) presents a critique of the medical model, its pros and cons, and especially its pitfalls and limitations when applied without perspective; (2) delineates how the faults and inadequacies of the model too strictly applied can be obviated by a better understanding of the relation of the illness to the life of the patient; and (3) outlines the goals, attitudes, concepts, and methods of a more comprehensive, more effective, person-centered care.

This book is not about being kind, thoughtful, or responsive to patients.

These are essential attributes of good care in any circumstance. By *person-centered care* I refer specifically to becoming familiar with the patient's personal situation in its crucial relationship to the source of illness.

Helping patients surmount the impact of chronic organic disease is a traditional concern of medical practice and an important aspect of care. The challenge of rehabilitation, of living as full a life as possible in spite of the disease, is covered in an extensive literature, of which I shall cite here only the major contributions of two Stanford investigators, Moos [1–2] and LeMaistre. [3] But again, these matters are not what this book is about. Here I will focus mainly on the personal distress that *causes* illness rather than the distress that *results from* the disability of chronic disease.

The book is addressed primarily to doctors, medical students, and care providers generally, both in medical and in psychotherapeutic practice. But the medical process, its problems and possibilities, is also of general interest, and the book is intended to provide such broader understanding, as well. Though written in the language of medicine, it is addressed to anyone concerned about the human elements of illness, healing, and health.

My interest in these matters began to take form when I saw my first patients as a medical student. I was an idealist, as are most health-care professionals. I had entered medical school with a scientific background and an insatiable curiosity about human nature. Science was clearly the basis of medicine. I had also read Freud, Jung, Adler, and William James, and although I questioned the validity of certain psychoanalytic postulates, I believed that human behavior and psychological illness could generally be understood. The purpose of medical care, I believed, was to understand the cause of illness and to remove or alter the cause so that healing could begin. The cause might be organic disease, it might be psychological or social, it might involve stress, alcohol or substance abuse, health habits or other problems of human life, or some combination of factors. No matter: I assumed that medical science and/or psychological understanding could reveal the source of the problem and offer ways to help. I was attracted to general internal medicine as a specialty that combined technical skills with an opportunity to know and work with patients at many levels. So I was interested in all kinds of illness and tried to understand the cause whenever possible.

After six years of residency and fellowship training at the University of California Medical Center in San Francisco, the Massachusetts General Hospital, the Postgraduate Medical School of London, and a tour of duty in the U.S. Navy Medical Corps during World War II, I entered private practice as a general internist with my partner and brother, Donald C. Barbour. I also attended the wards and clinics of the U.C. Medical School as a member of the

clinical faculty. After ten years of practice I joined the full-time faculty of the Stanford University School of Medicine as head of the Division of General Internal Medicine. My primary responsibility was the "G.M.C." (General Medicine Clinic) and the Stanford Diagnostic Clinic, its patients, students, and residents.

In medical school I had discovered that medicine was not what I had earlier supposed it to be. I was dismayed by the inordinate split between medicine and psychiatry. In medicine you do not "do psychiatry"; you diagnose and treat disease. In the clinics, however, there were few diseases but many symptoms, and the system of diagnosis and treatment often didn't seem to work very well. Excluding respiratory-tract infections, the most common problem in private practice, I found that organic disease adequately explained the illness in only about one-third of my patients. In fully another third, the illness was strictly functional, with somatic (or "psychiatric") symptoms, i.e., caused by human situations.

Here and throughout the book I use the phrase *human situations*, alternatively *personal situations*, to include all of the stresses, health practices, habits, physical strains, existential dilemmas, personality and behavior patterns, and emotional and social difficulties that can cause illness. These are all personal situations *that can be improved.* In the remaining third of my cases, the patients did indeed have a disease process, but the actual *illness*—that is, *all* of the symptoms and disability—was caused mostly by psychosocial distress not specific to the disease itself. This three-part breakdown is of course approximate, for there are no sharp divisions between these categories, but a similar analysis, with similar categories, appears consistently in published surveys of primary practice (references in Ch. 4).

With perhaps as many as half my patients, I learned that if I didn't know the person I didn't really understand the illness. And if I had no real understanding, it was less likely that the patient would become well, although a diagnosis—tension headache, for example—could be made and something—an analgesic or tranquilizer—could be prescribed to relieve symptoms. That, however, was not satisfying, not why I went into medicine, and usually the symptoms persisted or recurred anyway. I really wanted to understand the source of illness, whatever it was. Not knowing left me intellectually dissatisfied, and seemed unscientific. Care was far more effective when the patient and I came, *together*, to understand the roots of the illness, whether at the physical or the personal level, and better still when something positive could be accomplished at either level.

At the personal level, I found, realistic change in stressful life situations, relationships, attitudes, behaviors, or habits could not always be readily achieved simply because some understanding had been reached about what

was most needed. Nevertheless, at that point the patient would have options, paths to health, that had not previously been clear, and that scientific medicine alone had not provided. Most important, the patients became participants in their own health care.

Most patients want to understand their illness. They appreciate the opportunity to share their problems, whether they initially think they can do much about them or not. Some will then make dramatic personal changes and improve immediately. Most feel better from some combination of symptomatic therapy and an understanding of the underlying problems, though real changes can only be made over time. A few patients—surprisingly few, to judge from what I had been led to expect—do not want to share their concerns and feelings and insist on strictly medical interpretations of what are in fact straightforward psychosomatic illnesses.

All in all, if the patient and I—thus you and your patient—collaborate to determine the underlying problem situation and to combine what the patient can do about it with what medicine can do to relieve symptoms, we begin a far more effective patient/doctor relationship. It is also an easier, more satisfying, more straightforward, and more honest relationship. It means fewer visits, tests, drugs, unreasonable demands, and expectations. It is far less costly, and in the long run it takes less time. Gaining an understanding of who, why, and what the patient is all about is obviously most important when the illness itself can be understood in no other way. These points will be demonstrated throughout the text by illustrative case histories.

In contrast, when we try to explain and cure everything solely by the workups, diagnostic labels, and therapies of biomedicine, not only does the patient fail to get well, but serious trouble ensues. Diagnostic stalemates or frank errors, erroneous or misleading workups, ineffective treatments, habituating or hazardous drugs, and even unnecessary surgery are inevitable. Expensive, high-tech diagnostic procedures, often ordered in the search for a disease explanation of what are really unrecognized functional disorders, constitute a major component of the soaring costs of modern medical care.

My patients, and all they have taught me about their lives, illnesses, and medical care, provide the data base for the concepts in this book. The case histories cited are accurately recounted, although I have altered the names and identifying details sufficiently to preserve anonymity. Equally important are the creative perceptions of the students, residents, and colleagues with whom I have shared the unparalleled opportunity medicine offers to know and help patients.

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A. B.

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Dr. Allen Barbour died rather suddenly on August 8, 1993, when the manuscript for this book was completed. Allen was a retired professor of clinical medicine at Stanford University School of Medicine. Throughout his forty-year career of clinical experience and teaching, he sought a deeper understanding of the link between the psychosocial aspects of a person's life and the source of illness. His teachings of colleagues, residents, and students in this domain are revered by many.

Through his short illness, the strong advocacy and collaboration of his wife, Joan, and her commitment to the final editing posthumously are a tribute to his memory and this legacy of his life's work.

Virginia Fowkes

Senior Research Scholar
Director, Primary Care Associate Program,
Stanford University School of Medicine