



## Letters to the Editor

The following letter is a follow-up to David Clarke MD's article, "An Approach to Severe or Persistent Functional Symptoms," which appeared in the Fall, 1997 issue of *The Permanente Journal*.

*To the Editor.*—In January 1997, every practitioner in Northwest Permanente was invited to refer to a new clinic any adult patient with a possible psychosocial component to their physical symptoms. They could be referred regardless of the nature of their physical symptoms. The goal was both to diagnose and initiate treatment of the underlying psychosocial issues. Patients are seen for a one-time, 90-minute discussion. To date, about 100 patients have been seen in the Stress Illness Diagnosis Clinic (SIDC). Some of what has been learned from this group may help with a significant subset of our patients and may potentially save a large amount of resources.

The discussion during SIDC reviews the relation between physical symptoms and stresses from present-day life, posttraumatic stress, depression and childhood stress. The latter is defined as any treatment of the child that produces persistent lowering of self-esteem, and characteristics of the recovery from that treatment are reviewed in detail. Questionnaire data are collected and a summary is placed in the electronic medical record.

Eighty-eight percent of patients found SIDC to be very helpful (56%) or somewhat helpful (32%). Of those who initially did not believe their symptoms were very related to stress, 56% reported believing in a stronger linkage to stress for their symptoms after the clinic. Only 3% believed their symptoms were less likely to be due to stress ( $p < .001$ ). The average number of Medical Office visits for SIDC patients (per half year) declined by 25% after SIDC (from about 8 visits to about 6,  $p < .03$ ). A few referring clinicians have reported that a patient of theirs experienced complete resolution of symptoms after the clinic.

Despite strong evidence that 1/3 to 1/2 of outpatient visits are related wholly or in part to psychosocial issues, many clinicians find this a difficult area to discuss with patients. Approaching psychosocial stress like any other illness can be helpful. Here are some ideas supported by SIDC experience:

1. Because psychosocial stress is included in the differential diagnosis of most symptoms, raise the issue by telling patients that sometimes the brain attempts to alleviate stress by sending nerve impulses out into the body. Tell them these nerve signals then produce the symptoms when the signals arrive at the afflicted area(s).
2. Try showing them a line drawing of the brain and spinal cord. Draw an arrow that starts at the brain, and extends down the cord and

then to the site of their symptoms. This helps them think of stress with the same physiologic paradigm we are all accustomed to in thinking about illness. This works remarkably well. The earlier in the evaluation that you have this discussion, the more likely it will be perceived as thoroughness on your part rather than desperation. (So don't wait until you have "ruled out everything" before mentioning stress).

A. Some of the illnesses that can be explained (in some patients) via the nerve impulse mechanism include atypical chest pain, TMJ pain, "hypoglycemia," irritable bowel, chronic fatigue, "food allergy," headache, dizziness, pelvic pain, low back pain, "multiple chemical sensitivity," somatization, interstitial cystitis, panic, hyperventilation, unexplained dyspnea, globus sensation, repeated shoulder dislocations, and fibromyalgia.

3. When you suspect a psychosocial component to a patient's illness, there are three useful areas of follow-up inquiry: present-day stresses (including traumatic events prior to symptom onset), symptoms of depression (especially sleep disruption, fatigue, depressed mood), and events in childhood that resulted in persistent lowering of self-esteem (abuse, violence at home, etc). When these are discovered, appropriate treatment and/or referral can be initiated.

The more often this approach is used, the easier it gets. It can be time-consuming initially but the gratifying improvement in patients will, in the long run, save more office visit time than it consumes.

David D. Clarke, MD  
Gastroenterology  
Northwest Permanente

*To the Editor.*—I commend you for your open-minded "Systems Challenge" in publishing Dr. L. Segal's article, "Complimentary and Alternative Medicine Comes to Kaiser Permanente." Dr. Segal makes it clear that there is a substantial movement within our organization nationally that seeks to "continue exploring methods of integrating ... alternative medicine into our operations." She proposes teams of providers "of different types" to evaluate patients, using an acupuncturist and an internist as an ex-

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ample. The article recommends “coordinated care” of this type as a way to “strengthen our position in the marketplace.”

I believe that Permanente Medicine should represent scientific medicine based on theories which have been tested by reproducible, verifiable trials. Unlike scientific medicine, “alternative medical systems” have as a common principle reliance on anecdotes and religious-like beliefs to support their practices. These systems do not examine their own risks and failures or the amount of benefit provided by their cost.

Dr. Segal points out that our members, like the rest of the general population, have a substantial interest in alternative medicine. I am concerned that an uncritical pursuit of the “alternative medicine” share of the medical marketplace represents pandering to the masses, rather than the exercise of careful medical judgment which is our professional responsibility.

Joseph E. Beezy, MD  
Emergency Medicine  
Partner, SCPMG

*In Reply.*—In response to Dr. Beezy's letter, I would whole heartedly agree that “an uncritical pursuit of the alternative medicine share of the medical marketplace represents pandering to the masses, rather than the exercise of careful medical judgment which is our professional responsibility.”

We in the Mid-Atlantic Region (and the providers listed in the table supplied in the article with whom I have spoken) agree that the introduction of alternative medicine practices be based on scientifically designed research studies of solid validity and reliability.

Although our patients may rely on anecdotes and personal belief, we as trained medical professionals rely on findings published in peer-reviewed journals. One adds his or her own set of professional judgments and skills in diagnosis and treatment regardless of whether the information comes from traditional or alternative medicine. When designing our clinical referral guidelines, we are careful to use evidence-based research.

Clearly, some forms of alternative medicine have no proven clinical value to date, and these will NOT be introduced into Kaiser Permanente—at least in the Mid-Atlantic Region—or, I assume, in any KP region. However, we have patients who could clearly benefit from some of these modalities that do have clinically proven results.

I invite additional comment and conversation from my colleagues.

Lydia S. Segal, MD  
Regional Manager of Complementary and Alternative Medicine  
MAPMG

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*To the Editor.*—Congratulations on producing a very professional work, *The Permanente Journal*. I especially appreciate Spring, 1998, Vol. 2, No. 2, page 78, which depicts staff after production of four journals. The *journal's* value lies in good humor (I laughed a great deal) without political censorship. Keep up the great work.

Ralph J. Lamson, PhD  
Psychologist  
TPMG

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