Psychosomatic Medicine: Clinical Care & Education in Portugal [(*)]

Ramiro Veríssimo [(**)]

Introduction

Rationale

In a context of exponential growth of knowledge, among others, medical specialization progressively became an absolute need. Progress however hindered in counterpart a certain "Renascence mind"; leading to the imperious need to revive a holistic approach to the "man and his circumstances" (Ortega y Gasset) as the only way to deal adequately with the psycho-behavioural dimension involved both in health and disease. And that probably was the main contribution of the 20th century into medical intervention within this domain. As much as, in the last half century, the powerful medications that also became available, allowing us to control almost all of the more disruptive behaviours.

This is the context known as Psychosomatic Medicine; that is, how we may conceive evolution from a biomedical deterministic approach, under a reductionist perspective, onto a conceptual integrative model for medical intervention, as well as for research: the bio-psychosocial model (Engel, 1977, 1980).

Past

Nevertheless in Portugal, as well as in almost all other countries, the concept still is scarcely represented in Health Care, its practice being confined mostly to some psychoanalytically oriented psychiatrists and psychologists. What has led to the commitment of a group of interested persons in promoting this perspective; and ultimately to the creation, circa 1990, of the Portuguese Psychosomatic Society.

Present

While not credited as a medical specialty by the legally competent medical organization — *Ordem dos Médicos* —, and with no recognizable autonomous functioning, its clinical practice is almost completely excluded from the National Health System; it remains as a conceptual model only adopted individually by some, very few, psychiatrists (1); as a touchstone idiosyncratically adopted, in a localized manner, to tune pre-graduated medical teaching within the area of psychological and communicational skills (2); and as research paradigm for some post-graduated studies gravitating around the integration of biological, psychological and social factors in Medicine (3). Besides, in some sort of specialization just in the opposite pole of "Biological Psychiatry", the Psychosomatic Medicine area of clinical intervention is also being directly "assaulted" by some Psychology schools — mainly related to the psychoanalytical oriented "French School" —; or indirectly by some other in a reformulation in-between Health Psychology and Clinical Psychology. I would like to stress out that, in its pursuit of integration of a multidisciplinary approach, the Portuguese Psychosomatic Society welcomes the affiliation of these professionals without any reserve whatsoever. In the same way as many other specialties that, as in the case of Philosophy, do not come strictly from within a medical background.

Today's pressure of referrals from medical-surgical wards in the General Hospital has led to the emergence of the so-called Liaison-Psychiatry; however this sort of psychiatric support, that somehow pretends to assume and fully embody competence in Psychosomatic assistance, in doing so remits itself to a poor caricature, restrained to an intervention strictly from the self-proclaimed "biological" psychiatric mainstream perspective, disregarding everything that does not comply strictly with the diagnostic criteria for a given psychiatric disorder. Which in turn somehow result and rely, after all, on the support of the pharmaceutical industries and their enormously powerful resources. Within this clinical set psychotherapy is almost absolutely disregarded.

The paradox come about because when the reductionist perspective denies validity of all knowledge — unaccredited as scientific — whenever beyond reach of its deterministic methods, Biological Psychiatry must be considered but as a mystification while mimicking other specialties with their related scientific

---

(*) *European Network on Psychosomatic Medicine* Meeting [Berlin, 2005 July 8-9th]
Sponsored/hosted by the *Deutsches Kollegium für Psychosomatische Medizin*

(**) Ramiro Veríssimo, MD, PhD
Medical Psychology / University of Porto Faculty of Medicine
Alameda Prof. Hernâni Monteiro
4200-319 Porto / Portugal
e-mail: rave@netcabo.pt

foundations. This simply arises when it claims itself from the domain of the exact sciences, since in fact, although postulated as such, it does not really comply with a deterministic model which allows causal explanation and ultimately curing in the same way. As a matter of the fact all the psychopharmacological interventions known to present are empirical and hardly considerable more than symptomatic; not infrequently it even is rather difficult to tell apart where the disturbances natural history ends and the medications action begins. Nonetheless extremely important, obviously; it is just that, unlike what we are mislead to believe, psycho-behavioural disturbs do not conform with any of the three recognized medical paradigm, for these require necessarily an ethiopathogeny to be precisely established. And this is not the case within Psychiatry as we well know and learned to accept since Kraepelin credited as evidence, instead, the morbid evolution. That is to say that DSM is not about diseases, but syndromes; which have to be dealt in a high level of integration, necessarily taking into account biological factors side-by-side with the psychosocial ones that cannot simply be disregarded.

Future

Being no formally recognized in any way, thus having no facilities at all for out- or inpatients — despite the assumed need on the part of other medical specialties —, Psychosomatic Medicine has not yet met Engel's seminal postulates dating back to 1977. Not in Portugal, as well as in many other countries. Unlike a few others, though.

In order to change this, we have to consider the well succeeded cases and try to identify the causes for this difficult implementation of what may be considered as a revolutionary (Thomas Kühn) step further in Medical Care. Some of these causes, as abovementioned, are transversal in its origin: knowledge accumulation with its inherent need for specialization (1) and direct or indirect pressure from the Pharmaceuticals under the light of recent developments in neurosciences and molecular biology (2). But beyond these there are most certainly some other local causes, such as political, cultural — in an anthropological sense —, and/or upcoming from the respective level of socio-economical development. Happens that, if one wish to effectively contribute to change things, analysis — be it in a systemic perspective — must also consider this sort of causes. A study of such causes should thus point out the weaknesses and the strengths of the system. In one hand somehow responsible for the ultra-stability and resistance to change — morphostasis —; and on the other, as crucial to reinforce, if one is to facilitate the desirable changes — morphogenesis —. And then should also consequently result in an outline of suggested procedures and guidelines — firstly oriented to the administrative practice — designed and seen as fit to contribute to the desirable development and promotion of the model.

Under these considerations a few hints to identify some of those "crux points" follow in the next lines, as well as some suggestions of possible actions to be adopted.

Keywords

Psychosomatic Medicine, Bio-psychosocial Medical Model, Medical Curriculum, Medical Education - European Policy, Delivery of Health Care, Evaluation Studies, Health Financing, Health Care Reform, Health Care System Plans (organization and administration), Mental Health

Weaknesses

1. **Cultural, political & socio-economic context**

   To start with, while considering the implementation of social precepts established or recognized as adequate and desirable, it is important to assume a cultural context where collective interest is frequently assumed as subaltern. And this usual disregard towards the "*res publica*" (literally the "public thing") — makes it important to acknowledge:

   a. **System ultra-stability**
      The "least effort law" is a huge problem to conquer when one offers to practice the bio-psychosocial model instead of the so-called biomedical.
      And on the other hand, one more implication of the same systemic — economic — principle is that it requires an adequate explanatory reasoning of the possible added costs apparently involved in every change: "if we don't have the care, the illusion that we don't have the need takes place".
   b. **Low political commitment**
      Precisely in the same way goes the stability of "established interests", when, besides demagogic speech, there is no humanist reasoning occupying positions of political influence that would enable

to enforce changes. And this is somehow one of the main reasons why constrains imposed on development from within psychiatry itself and the health organization at large are so hard to reduce.

2. **Organizational / institutional constrains**

   a. The place where specialized medical interventions attain its peak is the hospital. And this environment of highly concentrated differentiation is the one chosen to medical education. Precisely because of that concentration of different areas of expertise. And this is the way the educators, the "gatekeepers in medicine", ultra-specialized themselves, emphasize the logical models in biomedicine, thus perpetuating the problem.

   b. After half a century of debate we still don't have School Hospitals for real; we even are somehow further distant from such a goal. Unavoidable co-existence between Med Schools and Hospitals simply result in an unfriendly neighbourhood with serious repercussions in daily institutional living. Our pyramidal "napoleonic" organization of civil services, tear institutions apart since the ministerial level onto the basis. Despite what should be their ultimately common interest, Med School and Hospital go on being two institutions completely apart. And nowadays the growth of the assistance undeniably imposes a huge pressure that tends to diminish the influence of Med School decisions. Somehow unfortunately, for this is how the heavy weight of "asylum Psychiatry" in the General Hospital imposes its Consultation-Liaison model on other Services as an assumed obstruction to a more Psychosomatic approach to clinical practice. When we would expect at least some institutional cooperation.

3. **Tension regarding the concept**

   Although the Medical Psychology and Psychosomatic approach have evolved from within the Psychiatric Department, joining forces has proven difficult. The fact is that while the goal of an integrated treatment is to add a psychotherapeutic approach to psychopharmacology — in medical settings that not only psychiatric —, psychotherapy still is considered distinct from the practice of biomedicine. When in fact psychotherapy does not exclude biomedicine; the other way round biomedicine rejects to dilute itself within the added complexity of bio-psychosocial formulations. And the Cartesian point of view prevails when recognizing psychiatric mental disorders, *strictu sensu*, on the "body side", or else behavioural disturbances under the scope of Mental Health, on the behavioural side; but not the essential bio-psychosocial unity inherent to every patient.

4. **Limited resources**

   Furthermore the threatened clinical practice is supported by planners, for when financial resources are scarce, the economic advantages of reorganizing care to facilitate collaboration, must be proven. Although its humanistic potential seems to be universally assumed, in our materialistic modern culture it won't have any chance to stand before economics. Unless clearly assumed by the generalized modern theosophical "scientifism" — the mystic belief in a science with a power that has no limits.

5. **Theory and ethics neglected**

   However this ambiguity in what concerns the medical model orienting practice can somehow result in pure mystification. Take the case of drug abuse. All the actors accept these persons as being ill. But doing so they must be accepting implicitly they are talking about a bio-psychosocial disturb that necessarily requires a bio-psychosocial approach to treatment. However in a General Hospital context what generally happens is a strictly biomedical treatment — detoxification — that seldom leads to anything else than successive relapses and huge amounts of money spent; as proven by any decent follow-up. We probably would better talk about toxicophilia, stressing the difficulties inherent to the person behind the steadily installed behaviour.

6. **Need of action**

   a. Medico-surgical wards, although willing of some sort of psychosocial support, they still don't have any teams working in an integrated manner.

   b. Although they already have a legal framework within the National Health System, there are but only a few Clinical Psychologists working as such. Most of them have to face enormous difficulties to get employed; which really is, at present, almost next to impossible, within the National Health System.

Many of them work year after year being only remunerated by their hope of eventually being in a better position to catch a job.

Strengths

1. **Post-graduation**

   a. We have a considerable amount of professionals who have conducted their post-graduation studies under the umbrella of this fruitful paradigm.

   What suggests the opportunity to reinforce available clinical teaching and research practice through clinical, research and teaching opportunities.

   b. Moreover some measures could be taken concerning mutual recognition of *Continuing Professional Development and Continuing Medical Education* (Declaration of Dublin) of Medical Specialists all over European Union. Namely on the criteria for international accreditation by the **European Accreditation Council for Continuing Medical Education (EACCME)**, in order to allow credits obtained abroad to be recognized by the national regulatory bodies.

2. **Pre-graduation**

   There is also some pre-graduation teaching within the area; although not fully assumed in the more conservative "classical" Med Schools. **Medical Psychology**, a pre-graduation discipline essentially devoted to the medical training of psychological and communicational skills, may adopt a strictly Behavioural Medicine approach; but may also be and often is more "Psychosomatically oriented". In any way it must be recognized as the clinical discipline that is in a better position to test its hypotheses and promote its goals.

   Therefore, implementing administrative models should take into account these pre-existing structures and synergies; thus facilitating financial viability. Although keeping teaching autonomy, because of its specificity and identity, Medical Psychology should be considered, with all its accumulated experience in teaching, research and clinical practice, as an asset; which should be put into good use as an adequate framework to C-L within the Psychiatric Department. And this could be the basis for an effective and practical implementation of an administrative model for bio-psychosocial teaching, research, and medical care.

3. **Unmet needs**

   There are many clinical areas, not only ready but wishful, as abovementioned, of such a bio-psychosocial intervention; for they recognize the need from the inside while clearly assuming they actually don't get it from conventional (as it is) Psychiatry. Over the years, in my academic position — Medical Psychology —, while relating with the General Hospital wards I have personally dealt with countless areas/topics such as these in a way or another — assessment and/or counselling —.

Promoting Psychosomatic Medicine

1. First of all, to put Psychosomatic Medicine on the European Agenda should be an endeavour of the **European Network on Psychosomatic Medicine (*ENPM*)**; striving to:

   - Enhance the value and visibility of Psychosomatic Medicine at European Level
   - Seek synergies and agree on strategies on European co-operation
   - Define priorities in the field
   - Develop European Psychosomatic Medicine policies
   - Stimulate relevant actions through various projects.

   In order to do so the network should establish as priorities:

   - Discuss priorities and propose activities (starting/ongoing)
   - Exchange experiences between countries (starting/ongoing)
   - Strengthening international collaboration (starting/ongoing)
   - Support actions toward Psychosomatic Medicine promotion

- Support research and development
- Plan and implement joint activities in the field

2. Considering the bio-psychosocial medical model as a conceptual advance over the biomedical, suggestion is made to be considered the opportunity for launching ***European Transnational Studies***.

To start with, in order to stress inequalities across Europe in what concerns Psychosomatic Medicine; then to point out some procedures of good practice in Health Care. Aiming at reducing such inequalities, as well as to establish guidelines of good practice, the resulting report on the state of Psychosomatic Medicine in Europe should thereafter, not only be duly published (…), but also properly publicized within the participating countries; namely drawing attention from a broader public through the mass communication media, since audience mean voters and political decisions. Key messages would be:

- Unapparent/somatized anxiety and depression must be assumed as health risk factors utterly important
- Psychosomatic Medicine must be seen as indissociable part of public health
- National Psychosomatic Medicine strategies need to be developed
- Psychosomatic Medicine should be taken into account in all levels and sectors of health policies
- Psychosomatic Medicine, to be understood, must have its emphasis shifted away from mental disorders into enhanced health and health related quality of life (implying lower health consumptions)
- Increasing cooperation can but result in added value

3. A first step towards reinforcement of good practice in what concerns clinical teaching and research, would also be a proposal for a **Common European Curriculum in Bio-psychosocial Medicine**, properly contextualized within the **European Credit Transfer and Accumulation System (*ECTS*)** framework.

The final proposal should then be addressed to local psychosomatic organizations (in order to be redistributed) as well as to Professional Education Committees and other key entities responsible for decisions being carried out in administrative (re)organization.

4. **European *Community Support Framework***

The article 152 of the European Union Treaty establishes the mandate in public health:

- "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities."
- "Community action shall be directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health."

Besides, in its primary objectives the **European Union Treaty** has assumed a principle of economic and social cohesion having in mind to assure harmonic development within its space, through reducing inequalities among different regions and the underdevelopment of the needier.

To fulfil those objectives, Member States of the European Union are entitled to get some **Cohesion Funds** (established by the Maastricht Treaty) as well as **EU Structural Funding**. That is, for their national development efforts in order to reach the desired cohesion. Among Structural Funds are the ***European Social Fund*** (education and training) and the ***European Regional Development Fund*** (productive investment and job creation, infrastructure projects, and local development initiatives). The application to this Structural Fund assistance is made on the basis of submitting *Operational Programs* (under the *National Development Plan*) to negotiations of a ***Community Support Framework*** to be approved by the European Commission/Directorate-General.

During the 1999 Berlin European Summit, Portugal, among all the others, has got some of these funds to commit in co-financing developing programs for the period of 2000-2005. Namely under Axis I of the Community Support Framework: higher the level of qualification, promote employment and social cohesion. A health operational program was conceived as a contribution to the structural reform of the Health Sector: **Health XXI**.

While programming the structural funds, Health XXI has three main strategic priorities. Namely to promote health and prevent disease (1), to improve access to a better health care (2), and to promote new partnerships and new actors in health (3). Each one of these prioritizing axis, in turn, involves a few independent measures. Axis two, improving access and quality of health care, captured € 516 030 876 — 70.6 % of the funds — (€ 385 710 048 from Structural Funding). It holds five of such measures; two of these I consider that would have been of particular interest: measure 2.1. — *Hospital Referral Network* — and measure 2.5. — *Modernization and Humanization of Hospital Services* —. From where I stand, in what respects a Psychosomatic approach to medicine, their name tells the whole story on the importance they could have had if only.

Nevertheless, as previously recognized, in what concerns the implementation of an administrative model for integrative care, this has been but a missed opportunity of gargantuan proportions. The bio-psychosocial approach simply goes on being ignored; or else being discarded from the mainstream while easily considered as somehow "non-scientific" by decision makers.

5. Action Plan for equity in Mental Health across Europe

Although widely recognized, the advantages of a holistic approach to health promotion and health development within a setting, it didn't in fact catch the train of equity across Europe within the Action Plan for Mental Health (Helsinki Conference, Jan 2005). Future actions in this context should be considered.

References

Ortega y Gasset, J. *Unas Lecciones de Metafisica* (Obras de José Ortega y Gasset - 14) Madrid: Alianza, 1981 [tr Mildred Adams. *Some Lessons in Metaphysics* (written in 1932-33) New York: W. W. Norton & Company, Inc, 1969, 1970]

McClintock, RO. *Man and His Circumstances: Ortega as Educator*. New York: Columbia University, Teachers College Press, 1971.

Engel GL. The need for a new medical model: a challenge for bioscience. *Science* 1977; 196: 129-136.

Engel GL. The Clinical Application of the Biopsychosocial Model. *Am J Psichiatry* 1980 137: 535-544.

Marmor J. Systems Thinking in Psychiatry: Some Theoretical and Clinical Implications. *Am J Psychiatry* 1983; 140: 833-838

Gallagher RM, McCann WJ, *et al*. The Behavioral Medicine Service. An administrative Model for Biopsychosocial Medical Care, Teaching, and Research. *General Hospital Psychiatry* 1990; **12**: 283-295

Kraepelin, E.. *Psychiatry: A Textbook for Students and Physicians*. Science History Publications, 1990.

Diagnostic and Statistical Manual of Mental Disorders – 4th Ed Text Revision (DSM-IV TR). Washington D C: American Psychiatric Association, 1994.

Kühn, T. *The Structure of Scientific Revolutions*. Chicago: University Chicago Press, 1962, 1970.

Deutsch F, Jores A, Stokvis B, Freyberger H, Stunkard A (eds). *Training in Psychosomatic Medicine* (Advances in Psychosomatic Medicine Series – Vol 4). Basel, Schweiz: S. Karger, 1964.

Novack DH, Waldstein SR, Schindler B, Ochitill H. Designing and Implementing a Comprehensive, Integrated, Longitudinal Medical School Curriculum in Biopsychosocial Medicine.

Bentes *et al*. *Health Care Systems in Transition: Portugal*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004. [The organizational structure of the Portuguese health system]

ECTS User's Guide - European Credit Transfer and Accumulation System and the Diploma Supplement. Brussels: Directorate-General for Education and Culture, 2005

The Bologna Declaration. Joint declaration of the European Ministers of Education. June 1999.

Lehtinen Ville. *Action for Mental Health. Activities co-funded from European Community Public Health Programmes 1997-2004*. Luxembourg: European Commission (Health and Consumer Protection Directorate-General), 2004 [http://europa.eu.int].

The State of Mental Health in the European Union. European Commission (Health and Consumer Protection Directorate-General), 2004 [http://europa.eu.int].

Jané-Llopis, E. & Anderson, P. *Mental Health Promotion and Mental Disorder Prevention. A policy for Europe*. Nijmegen: Radboud University Nijmegen, 2005.
[This document is a result of the project "Integrating mental health promotion interventions into countries' policies, practice and the health care system" on behalf of the "Implementing Mental Health Promotion Action" (Imhpa) network: http://www.imhpa.net]

Mental Health Action Plan. In *The Helsinki Conference — Conclusions*. WHO, European Commission and Europe Council, Jan 2005.