

Family medicine is a very different speciality to secondary care or specialist care medicine. A whole new set of knowledge and skills need to be acquired by the doctor moving from hospital specialist medicine to family medicine in the community. Part of the reason for this is the completely different presentation of illness in a family medicine setting.

Traditionally, medicine has dealt with patients and diseases. The common pattern of medicine is that a patient is a person who has a disease. The disease has a cause. If the cause is dealt with, the disease disappears and the patient becomes a person again. Over the past fifteen years it has become clear that this picture is inadequate to explain many medical consultations. The classic work on this subject was done by Zola in Massachusetts, USA. He showed that what brought people to a doctor was not necessarily a disease at all. Zola's work has been repeated and confirmed by McWhinney in Canada, Howie in Edinburgh, and other workers in Holland, Sweden, Italy and Finland. Why then do patients present to doctors? What do we mean by illness and what is a disease?

## HOW PATIENTS PRESENT

Most patients present to their family doctor with either a symptom or a problem. In population surveys, it has been found that at any one time, more than 80% of the population have symptoms. Stewart McWhinney and Buck have shown that the severity of the symptom is not a reliable indication of whether it will be presented to the doctor. Several quite separate factors determine whether patients present to doctors — and these factors seem reliable predictors of consultation with the doctor across widely

varying cultural divides. What then are these factors?

1. **Limit of Tolerance.** Above a certain threshold, symptoms are reliably presented to doctors, thus few people with acute pancreatitis or an acute ischaemic limb do not present.
2. **Limit of Anxiety.** A relatively mild symptom that is interpreted as indicative of a serious disease may be taken to the doctor. For example, a chest pain is presented to a doctor at a lower level of intensity than a limb pain. A person worried about a melanoma may rapidly present a tiny, innocuous freckle.
3. **Unrelated Personal Crisis.** If a person is upset or anxious, he or she will present a symptom to the doctor earlier than when they are happy or contented. Recent work in the UK has shown that when people are made redundant, they consult their family doctors much more frequently for symptoms that they would previously have coped with by themselves.
4. **Interference with Lifestyle.** Symptoms that interfere with a person's job or social life will be presented early. For example, a strained leg muscle would be presented earlier by a ballerina or a labourer than by a typist.
5. **Social Sanctioning.** Most people discuss their problem with family and friends. Sometimes these friends will send people along to their doctor who would otherwise not have attended because the friends are concerned about the cause of a symptom.
6. **Failure of Self-Medication.** All over the world it has been

found that family doctors are not the first recourse for people who feel unwell. Many people take household remedies first and only present to doctors when their own medication has not produced relief.

7. **Contact with Illness.** The relatives of sick people consult doctors significantly more than average and about milder symptoms. This may be because of a disturbance of their narcissism or because they perceive the cause of their relative's illness influencing them too.

## PRESENTATION OF THE PROBLEM

When the patient comes to the doctor the problem is usually presented in terms he has previously learned are acceptable to the doctor. The problem may be presented as a diagnosis: "Doctor, I've got tonsillitis." It may be presented as a request for treatment or a certificate, or the patient may have learned to present his troubles merely as a symptom or problem, leaving the doctor the satisfaction of giving it a name.

Occasionally the problem is presented non-verbally by the patient breaking down crying, or in a hidden way as an afterthought to another minor symptom. The way that the patient presents varies according to what he wants done, how the doctor has taught him is acceptable to present problems, and how the patient understands the concept of disease.

## DIAGNOSIS AND MANAGEMENT PLAN

Traditionally, when a hospital doctor sees a patient he perceives himself as taking a full history and

doing a thorough examination. He will do relevant tests. A diagnosis will be made, the patient will be treated and then discharged. Doctors moving into family medicine are surprised to find a different system of reaching a diagnosis.

In family medicine, a hypothesis about the nature of the problem is made early in the consultation with relatively little information collected. Much of the consultation is then concerned with testing this hypothesis and discarding, revising or confirming it by a search for information. An important part of the information used in this process of diagnosis is gleaned from the family doctor's knowledge of the patient's family and from his notes. Much of the decision-making, both in formulating a hypothesis and in testing it involves a binary mode of thought: is the patient's problem urgent or not urgent? The patient has an acute abdomen or does not have an acute abdomen; he needs attention tonight or he does not need attention tonight. This is different from collecting facts and then making decisions by logical inductive thought, which the hospital doctor perceives himself practising. One interesting sideline is that evidence being collected at Dundee University about hospital consultations seems to indicate that hospital consultants actually do *not* make decisions as they perceive themselves doing. It seems that on the whole, they use the same binary mode of thought as family doctor but they didn't realise that they were doing so.

#### PATTERNS OF GP MEDICINE

Much of family medicine then involves a cue hypothesis search confirm or revise system of diagnosis. This is one aspect of the widely different perception of working methods of family doctors and hospital doctors. The family doctor accepts a responsibility for making an initial decision on every problem his patients present to him.

The hospital doctor's role is usually limited by his speciality or by the area of the hospital he works in, e.g. the accident department.

Family doctors usually have to make a decision in a consultation lasting between 5 and 15 minutes. Illness presents at an earlier stage in family medicine and physical signs are often absent. The history is of greater importance than signs and decisions have to be made at a lower level of probability. Even the history may not comply with what the textbooks say. Most medical textbooks are written by hospital doctors. However, by the time patients reach hospital, they have thought about their problem, talked to their family doctor and he has helped the patients to organise their thoughts into a form understandable to the hospital doctor. This is not the stage the problems present to us and great skill is needed in dealing with these early stages of presentation.

The decisions taken after diagnosing a problem also differ in family medicine. A family doctor may decide that he will wait and see what happens without treating a person with, say, rheumatoid arthritis — many of them remit. If the patient reaches hospital, this usually means that they have not got better either with the passage of time or with the treatment given by the general practitioner, so a more active role is usually taken by the rheumatologist.

The general practitioner also has to deal with multiple problems, and individual problems that affect patients physically, socially and psychologically. The action taken for any one problem may be influenced by its likely effect on other problems, or by the effect on a different part of a patient's life. In some consultations, the general practitioner never defines what the problem is: the patient may use the doctor as a resource person, or as a sounding-board with which to solve his own problem without revealing its nature.

#### MODELS OF DISEASE

If the doctor is to define a problem sufficiently to help with its resolution, he must make that problem fit into a category that renders it understandable to him. This means that he must fit it into a model of disease that has (a) an understandable reason, (b) an understandable present state, and (c) an understandable course.

In order to make the problem fit into a model, the doctor must know

- the nature of disease
- the nature of the patient
- the nature of the environment within which the patient experiences his disease. For example, a viral sore throat presents differently in a man bored and about to retire from his job, than in a young man about to go on holiday.

The doctor may have no difficulty in fitting a problem into a disease category. However, most patients will also have categorised the problem before they consult the doctor. If the models differ, there may be difficulties.

If a man presents with epigastric pain that awakes him at 3 a.m., is relieved by antacids and a previous barium meal showed a scarred duodenum, the doctor has no difficulty in fitting this discomfort into the category of a recurrent duodenal ulcer. He may prescribe cimetidine [Tagamet]. However, if this same patient's father-in-law, after a period of epigastric pain, was found to have cancer of the stomach and is now terminally ill, the patient's model of disease may be different from the doctor's. It is by no means certain that the patient will tell the doctor his worry.

However, if the doctor does not find out what the patient feels is wrong with him, and just prescribes cimetidine, it is unlikely that the patient will comply with the treatment. The treatment will be unsuccessful, and the patient will

attend frequently for his epigastric pain. The patient will become anxious: he will be less able to cope with other symptoms and will present these more frequently to the doctor as well. Eventually, both the patient and the doctor may get frustrated and irritated.

### PATIENTS' AGENDAS

When patients attend doctors, they do not come with a problem and a blank mind. They usually come with an agenda, i.e. something that they want done. Patients usually do not tell their doctors what they want done, and if they do, the doctor is often annoyed. Most doctors do not like to be faced with a demand for penicillin; they prefer to make the diagnosis of tonsillitis — which the patient already knew because he had looked down his throat before he came — before prescribing penicillin. Our patient with epigastric pain wanted tests to exclude cancer, not treatment for an ulcer. Patients may come to a consultation wanting any or all of the following:

- a certificate
- tests
- a diagnosis
- a medical reason for what they have already decided to do
- to be confirmed in the sick role
- to be reassured that somebody cares.

Usually, if the doctor does not fulfil the patient's agenda, the patient will present again with problems that are more likely to fulfil his aim.

### ORGANISING DISORGANISED PROBLEMS

If the doctor is to treat the whole person presenting to him, and to fulfil the covert as well as the overt aims of the patient in each consultation, he must:

- find out why the patient has come

- find out why the patient feels this makes him unwell
- find out what the patient perceives as the cause
- find out what the patient's expectations are of the doctor
- find out what the patient's expectations are of treatment
- negotiate a problem description
- negotiate management ideas
- interpret these in physical and emotional terms, and in terms of the patient's lifestyle
- if the patient is to be referred to another agency, the doctor and patient need to agree on an organisation of the problem that will be understandable to that agency.

In many consultations this process will be relatively easy and will progress smoothly. This will be more likely to happen if the doctor and patient know each other and each has an accepted role. Circumstances where difficulties are more likely to arise are as follows:

1. Where the Patient is Inarticulate. It may be difficult for the doctor to determine why the patient came and what he wants. In some cases the patient himself may find it difficult to define his problem. Such a consultation may progress through several appointments with the doctor before a satisfactory problem definition is reached. Irritation shown by the doctor may prevent such a definition ever being reached, and may lead to multiple unsatisfactory consultations.
2. Different Models of Disease. Patients whose models of disease differ from the doctor's may present problems in consultation. Where the patient sees his illness as caused by God, Allah, or by somebody who has cast a spell, a prescription of a medicine is unlikely to lead to a resolution of the problem. The doctor has the difficult

task of negotiating a problem definition with somebody whose cultural beliefs differ widely from his.

3. Signal Behaviour. Some patients present their problems in a hidden manner. This may either be because they are uncertain whether the doctor will accept the problem, or because the patient is too frightened to confront the problem. A typical demonstration of this behaviour is the patient who produces his main problem just as he is leaving the consulting room, or the lady with a lump in her breast whose presenting problem is a cough.
4. Games. Some people play games in the consultation. Often, these are extensions of games that these patients play in their everyday lives. A typical game is "Yes, but...". The patient produces a problem and the doctor presents a solution. But for each solution, the patient has a reason why it will not work. This continues until the doctor is defeated and it is proved that the patient's problem is no fault of his, and he bears no responsibility for it.
5. Hidden Agendas. Sometimes it is impossible to define the problem that the patient is presenting because he has an ulterior motive. The motive of the consultation may be to seek the continuation of the sick role to relieve the patient of intolerable responsibilities. Alternatively, the patient may just be seeking the continuation of a relationship with the doctor, the only person with whom he feels safe. Unless this motive is uncovered, the problem will never be resolved.
6. Misunderstanding the Triggers to Consultation. If the problem is accepted at face value, rather than questioning

why this problem was presented at this time, in this way, then the trigger leading to consultation may not be defined. The patient may be presenting a problem, as we said at the beginning, not because of its severity, but because his tolerance of anxiety and/or discomfort is reduced as a result of other circumstances in his life. If this trigger factor is not defined as the main problem and dealt with, numerous other problems normally tolerated as discomforts will be presented for medical help. (The average person has a new symptom every six days).

7. The use of "Target" Patients. In sick families, the problems of the family group may be rationalised by defining one member as sick. Howie described how, when women were weaned off tranquillis-

ers, they presented their children to doctors more frequently for minor illness. The mothers' anxiety was expressed by defining the children as ill. Accepting the problem as presented, and dealing with each of the child's discomforts, would lead to a perpetuation of this behaviour pattern.

## CONCLUSION

It might seem impossible to practise good medicine in family practice. Not only are we expected not to miss a wide range of major diseases among the patients passing through our doors every six minutes, but we must also practise prevention, we must counsel, we must prescribe frugally and generically, and we must audit what we are doing. It all sounds impossible when one considers that the problem presented by the

patient himself may not always be accepted at face value. However, family practice has one resource that makes possible the practice of good medicine: the relationship between the doctor and the patient and his family is usually a continuing one. This means that the patient can be trained by the doctor to present his problems in a way that can be understood. The doctor can be trained by the patient to consider him in his unique life situation. The notes, if well-kept, give a continuing record of this relationship. A consultation can go over several meetings in the surgery, in the patient's home and even in the supermarket.

It is this investment in shared knowledge and trust that should allow the continuing care of patients as whole people in family practice, despite the disorganised mass of problems and discomforts presented to the doctor.

