Editorial

PATHWAYS TO DIAGNOSIS

THE prompt diagnosis of major disease depends on two factors: patients must report their symptoms as soon as these are noticed and the general practitioner must be attuned to recognize the significance of these early symptoms.

The problem of diagnosis in general practice is bedevilled by the sheer bulk of material, often quite trivial, which presents. Already there is a major diagnostic problem in the sorting of wheat from chaff. The problem can only be made more acute by encouraging the early reporting of symptoms. How then can we cope?

The best diagnosticians amongst us will agree that there is always room for improvement in the methods we use in reaching a diagnosis. These processes, which differ widely from those taught to us in our teaching hospitals, were developed, often highly successfully, from experience of work in general practice. For most of us, however, the steps along the path to diagnosis remain ill-defined and any non-statistical description must depend on general impression, which is notoriously fallible. If we are to teach general-practice diagnostic processes and, even more important, if we are to improve upon them there is a need for precise definition of the pathways taken from first meeting a patient to the conclusion of diagnosis. How much do we depend on such unscientific but vital factors as previous knowledge of the patient, observation of minute changes in appearance and even on intuition? Do we use the laboratory, x-ray department and our consultant colleagues as often and as appropriately as we should?

Although each of us is faced with the same diagnostic problems we probably have widely varying methods of reaching our object (and possibly widely varying degrees of success). With this varying methodology we have much to teach each other but cannot do this because impressions of the way we work are inexact.

If there is inexactitude about the way we, as doctors, behave then the behaviour of our patients is even more vague. What brings one patient hurrying to the surgery with a minor ailment while others stoically endure major symptoms without 'bothering the doctor'? In many cases this is a matter of personality but many other factors, such as sex, age, social class, marital state may have a bearing on the way patients behave. The differing response of patients to medical care is well exemplified in the case of cervical cytology. In British Columbia 75 per cent of the population has been screened but this has only produced a 30 per cent drop in the death rate for cervical cancer. The 25 per cent who do not apply for the test include 70 per cent of those dying of cervical carcinoma.[1] In fact the wrong people are being screened. In this case the reason is probably poor motivation related to low social class but it demonstrates selection of available medical facilities by sections of the community.

In a survey of 1,000 consecutive new consultations in rural general practice[2] differences in consultation patterns related to social class were demonstrated. Because of the small size of the sample based on one practice and one doctor's work the picture was bound to be incomplete and liable to bias. However it was possible to draw the hypo-

thesis that a given patient might or might not consult his doctor about a given symptom depending on the psychosocial attitude held to that symptom by his social class group.

The survey also provided a measure of the way in which one doctor went about the diagnostic process and some of the reasons influencing the decision tree.[3] There is a need for a much more widely based survey, examining patient consultation patterns for many socially definable groups in several practices throughout the country. At the same time diagnostic methods must be studied in the hope that an ideal picture may appear which can then be used for teaching new entrants to general practice.

The collection of data for such a survey inevitably adds somewhat to the workload of doctors taking part but the yield of information is enormous and well repays the effort involved.

Arrangements for the processing of such data are already well advanced, programming is nearly completed and computer time has been promised at Warwick University. All that is required now is the collection of a large body of data; it is hoped that 20 to 30 doctors will take part.

Any general practitioner interested in collecting data for this study should write to Dr F. M. Hull, 6 Chestnut Square, Wellesbourne, Warwick.

REFERENCES

1. Editorial, *Brit. med. J.* 1969, 2,585.
2. Hull, F. M. 1969*a*. J. roy. Coll. Practit. **18**, 65.
3. Hull, F. M. 1969*b* (not published).

General practitioner's view of the home nursing service. F. A. BODDY, M.B., Ch.B., D.P.H. *Brit. med. J.* 1969. **2**, 438.

A random sample of 500 general practitioners in Scotland were circularized about possible developments in the home nursing service. Thirteen per cent of those circularized had a district nurse attached to their practice and of the remainder, 70 per cent would like such an attachment. The advantages most noticed by those who had district nurses attached to their practices did not completely accord with the benefits anticipated by those who did not have but wished such attachments. However, the supervision and follow-up of patients on behalf of the doctor was a popular choice in both groups. Most practitioners were of the opinion that many of the jobs at present done by the district nurse, could be equally well done by a state-enrolled nurse working under supervision.