Coleen—the general practitioner's role in her primary medical care

R. D. ERRINGTON*, B.Sc., M.B., B.S.

In this account I would like to present the story of Miss C. V. (Coleen), aged 22, who registered as a temporary resident with her general practitioner on 12 October 1972. She came to central London from Bradford where she had spent several months as a hotel secretary. The parental home was in Whitby, a rural part of Yorkshire, where she had lived most of her life. Coleen had found what she regarded as superior employment in a large London hotel.

Central London is renowned for its constantly shifting population. In the practice to which I was attached the number was approximately 20 per cent of the total list of about 10,000 patients. There were three doctors all under 40 years of age in this practice. It may be relevant that the proportion of young patients in this practice (about 50 per cent under 30 years of age) bears some direct relationship to the age of the doctors. Several of Coleen's young colleagues were registered with the practitioner she chose to consult and this perhaps exemplifies one of the many methods used in choosing a general practitioner.

Her first consultation coincided with her registration with the London general practitioner. She complained of headaches and nausea which had been intermittent during the preceding fortnight. These symptoms followed a persistent mild fever, from which she had now recovered, during which she had not sought medical advice. Physical examination failed to reveal any clinical signs of an organic disease process. In the management of all patients the general practitioner must establish a data base, relevant to each individual patient's physical health and life style, if patients' problems are to be managed in terms of their physical, social, and psychological status.

Some of the factors relating to Coleen's social background were recorded at her first consultation and have been outlined above. Her past medical history revealed tuberculosis as a child. A chest x-ray (requested in view of her history of tuberculosis) revealed only old calcified scars in the right lung. She was not anaemic and a differential blood count (ordered because of the vague history of a mild but persistent fever) gave results within normal limits. The erythrocyte sedimentation rate (Westergren) was slightly elevated at 12 mm/hour. Coleen was reassured that her symptoms were not due to any physical illness, but was advised to return for another consultation should her symptoms persist.

In an attempt to familiarise himself with Coleen's medical history, the new doctor wrote to her former practitioner in Whitby requesting her previous medical records. Such communication between doctors is vital if effective primary medical care is to be given to the community, whether the latter be permanent or nomadic. As no physical diagnosis was made at this stage her management was supportive by her being made aware that her practitioner acknowledged the existence of her problems and that she was free to consult him again if they did not resolve. This approach is particularly important if a successful doctor-patient relationship is to be nurtured. Here Coleen's practitioner had, at the first consultation, built up a picture of her social background both past and present. Having had experience of other patients newly arrived in London to a more urban environment, the practitioner was aware of the mental stresses that this could impose upon his patients.

At this stage, therefore, Coleen was embarking upon a new life in a strange environment. Would she be able to withstand the new stresses or would she fail to compensate and adjust to her new life style? After her first consultation these factors were still unknown particularly in the absence of previous records (a situation never rectified throughout her stay in London). Recognition of these possibilities by the London practitioner might, however, be beneficial to Coleen's future care considering that many aspects of physical, social, and psychological management are so interdependent.

*Formerly medical student, St. Mary's Hospital, London.

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Pickles (1939) was one of the first general practitioners to illustrate effectively how simple observational methods of recording in general practice could be used to study the patterns, profiles, and natural histories of some common diseases in his rural practice. Pickles' approach is still applicable to the epidemiology of modern general practice, with particular reference to the recognition of social and psychological factors and how these influence the patterns of disease as they now present to the general practitioner.

Coleen did not consult her practitioner again for four weeks (November 1972). She was recovering from an upper respiratory tract infection but complaining of abdominal cramps. No physical illness was diagnosed but the ensuing conversation revealed that life in London did not come up to her expectations. Her accommodation was one small room and friends were not easily made in the hotel.

Gynaecological problems

By December 1972 she had a boyfriend and she consulted her practitioner with a request for oral contraception. This led to enquiries into a part of her medical history which had not yet been discussed. Here it transpired that Coleen's menarche was of late onset (when she was 18 years old) and although menstruation was normal for the first year, its frequency declined and she had not menstruated since December 1971. The initiation of oral contraception under such circumstances was considered to be more in the domain of a specialist and an appointment was made for Coleen to consult a gynaecologist in January.

He was unable to attribute her secondary amenorrhoea to any definitive physical cause and tentatively diagnosed the Stein-Leventhal syndrome on the basis of her menstrual history alone. He discovered that Coleen had undergone a laparoscopy and received some " hormone " therapy whilst living in Bradford. The findings of the former were apparently negative and the latter failed to induce menstruation. Thus the gynaecologist considered that further investigations should be postponed until further information could be obtained from the hospital in Bradford. Oral contraception was thought to be contraindicated and the insertion of a coil (despite her being nulliparous) was suggested as an alternative means of contraception. Coleen's anxious state of mind, markedly bitten nails, weight loss and mild anorexia were commented on. These symptoms and signs were regarded as sufficiently significant for the gynaecologist to advise her general practitioner that perhaps referral for a psychiatrist's opinion might be in Coleen's best interests.

During January 1973 Coleen consulted her practitioner five times. She was suffering from recurrent upper respiratory tract infections, otalgia (diagnosed as bilateral otitis media) and vomiting after meals associated with a pain in her left iliac fossa. At her last consultation in January she looked unwell and had just menstruated for the first time in many months. The second, fourth and fifth visits were supportive follow-up consultations arranged by her practitioner. During this period an antibiotic (erythromycin) was prescribed for her ear infection which resolved under this treatment.

The respiratory tract infections, diagnosed as being of viral aetiology, ran their natural course and so supported the original diagnosis.

When she presented complaining of vomiting and left iliac fossa pain the only physical finding was a palpable sigmoid colon. Constipation was diagnosed and this hypothesis was supported by the subsequent resolution of the problem following the administration of a course of ' Mil-Par '. The physical problems coincident with her menstruation responded to a short course of ' Navidrex K '. All laboratory tests at this time returned results within normal limits. The only exception was an elevated erythrocyte sedimentation rate (Westergren) of 30 mm/hour. This caused some concern and alerted her practitioner to the possibility (despite the recent infections) of some underlying organic disease not yet clinically manifest. The problems were still undefined and it had become difficult to elicit whether her unhappiness was of environmental or psychological origin or perhaps a phenomenon secondary to her recent recurrent infective episodes. Whether or not the frequency of the latter could be considered within normal limits was also questionable.

Perhaps these important considerations would not have emerged had Coleen not been seen by the same practitioner since coming to London. If this is acknowledged then her story so far illustrates the value, to both patient and doctor, of the principle of the "extended cumulative consultation " in general practice.

With the practitioner's knowledge of Coleen's physical complaints and her social background, the need for future consultations was apparent. These were necessary not only to monitor her physical health but also to enable her practitioner to fulfil his supportive psychotherapeutic role. Coleen's frequent consultations (despite the multiplicity of proven physical conditions) perhaps indicated that the supportive role had been operational for many months. The practitioner, by being available to discuss their problems, endeavours to help his patients. The objective is not that patients become dependent upon their practitioners and thus escape from their problems, but rather to help patients recognise their problems and to help them to adapt optimally to a difficult environment.

Coleen's physical condition had improved when she was seen in February and her erythrocyte sedimentation rate was within normal limits. No evidence of organic disease was detected when she again presented complaining of abdominal pains and diarrhoea. Diazepam 2 mg t.d.s. was prescribed with little effect. She admitted subsequently to feeling "fed up", appeared increasingly withdrawn and complained of deafness. Her practitioner examined her ears and was unable to find any organic auditory or neurological abnormality despite his observation that she had difficulty in concentrating.

In the absence of organic disease the doctor's attempts to fulfil a meaningful supportive role were somewhat thwarted by Coleen's apparent inability to articulate her problems. Direct questions concerning her family background, friendships, anxieties and fears yielded little that could effectively help her. The stresses of her new environment seemed to be taking their toll and her involuntary withdrawal was her last defence.

More physical complaints

Finally, in March 1973, Coleen's physical complaints re-emerged. The mild persistent fever of unknown origin recurred and the lack of positive physical findings left the practitioner with the choice of a vast number of investigations or referral to a specialist in general medicine. Before doing this several investigations were undertaken, the choice of tests being initially selected in view of Coleen's former rural environment. The agglutination tests for *Brucella abortus* and the *Toxoplasma gondii* dye test were both negative. Coleen now decided to return to the North of England and thus further information regarding her progress is not available.

Coleen's story since her arrival in London illustrates several important points regarding her primary medical care provided by her general practitioner. Management of her physical complaints was effected with regard to her social and psychological status and at no time was either of these aspects neglected. The likelihood of some organic disease process was always considered in spite of her frequent presentations with problems which suggested an element of psychological overlay.

Which of her problems emerges as the most important, considering the possible effect on her life style in the long term, is still a matter for conjecture. Supportive psychotherapy scarcely affected her unhappiness and perhaps she has most helped herself by leaving the London environment to which she never really adapted. Coleen's physical symptoms demanded constant surveillance. Despite the absence of findings indicative of a recognisable chronic organic disease the practitioner still cannot exclude such a cause as being primarily responsible for her apparent difficulty in adapting to the stresses of her altered *modus vivendi*. How Coleen readjusts having returned to her more familiar environment will now be significant in assessing this, also her need for further physical and psychological investigations and treatment.

Details of Coleen's physical, social and psychological problems and their management are being forwarded to her new general practitioner as subsequent developments will warrant their consideration. Although at this stage Coleen's story appears without a definite beginning or ending, acknowledgement of these latter points emphasises the importance of recognising the continuous nature of primary medical care in general practice.

REFERENCES

Pickles, W. N. (1939). *Epidemiology in Country Practice*. Republished by the Royal College of General Practitioners (1972). London: R.C.G.P.