The aetiology of consultation: a threefold classification

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SUMMARY. A threefold classification of aetiological factors in consultation is suggested, for use in day-to-day clinical general practice.

Introduction

IT is common experience among doctors that clinical practice provides a constant flow of apparent anomalies. Patients with no definable disease consult the doctor, while much illness or established disease in others remains unreported. Treatment regarded by the doctor as important is neglected by some patients, while others constantly seek treatment for illnesses that are essentially self-limiting. Some patients are reluctant to shelve responsibilities or stop work when this is plainly desirable: others are equally reluctant to return to work, are rehabilitated only with the greatest difficulty, or remain invalids.

Such anomalies illustrate the truth of Caleb Parry's remark that "it is as important for the physician to know what sort of patient has the disease as to know what sort of disease the patient has"; and they also underline the doctor's need to define clearly the psychological and social ('behavioural') factors influencing the natural history and outcome of his patient's problem. To achieve this the doctor needs to apply to them much the same methods as he has traditionally used to understand physical disease—observation, classification, and comparison. Without a framework of classification he cannot make sense of his experience and turn it to practical use. In particular he needs a framework on which to classify:

1. Stages in response to illness.
2. Precipitating factors in the decision to consult.
3. Conditioning factors in the response to illness.

I describe such a threefold classification.

A classification of the stages of response to illness

The supposition that when a person is diseased or believes himself to be diseased he will consult a doctor is, as we have seen, misguided. Equally misguided are the assumptions that the patient, having consulted the doctor, will comply with his advice; that the patient who is 'cured' will return to normal activity; or that the patient who ceases to consult is free from, or adjusted to, his symptoms. Often none of these are true.

Before he can hope to unravel the aetiology of these apparent anomalies, or understand the real context of a consultation, the doctor needs a complete picture of the stages of illness. In recent years a number of conceptual models depicting these stages have been suggested, and some are of practical help to the doctor in providing him with a framework from which to understand what is happening.

For example, Suchman (1965) suggested that a person's experience of an illness could be classified into several recognizable stages which might follow each other in orderly or disorderly progression. Table 1 is adapted from his writings.

A model of this sort is of practical use to the doctor enabling him to review the processes which have contributed to repetitive, precipitate, or delayed consultations. Using it, he can begin to assess, for example, whether delay was due to a failure to perceive the importance of the symptoms, to a misuse of lay advice, to a 'flight into health', or to a spectrum of reasons causing the patient to reject the idea of 'going sick'. Similarly, he can review the stages that have led up to his patient rejecting treatment, or adopting a state of chronic dependence and invalidism; and the conclusions he comes to in each instance will influence the tactics and emphases of his management.

A classification of the precipitating factors in the decision to consult

It is well recognized that the precipitating factors which

Table 1. Stages of illness (adapted from Suchman, 1965).

EXPERIENCE OF SYMPTOMS ↓		FLIGHT INTO HEALTH ↑ Alternative actions	
Stage	Decision	Acceptance	Rejection
1. Perception of abnormality	Decides that "something is wrong"	Use of lay advice, traditional remedies, and self medication	"Ignore it and it will go away"
2. Adoption of the 'sick role'	Decides to relinquish or reduce his usual responsibilities	Seeks lay approval for 'going sick'. Continues lay remedies	'Weighs the odds', and rejects idea of going sick
3. Recognition of need for professional help	Decides to consult doctor	Seeks professional advice on treatment, and approval or disapproval of 'going sick'	Rejects doctor's opinion in whole or part
4. Dependence	Decides to accept advice and follow treatment	Complies with doctor's proposals	Rejects proposals in whole or part
5. Recovery and rehabilitation	Decides to give up sick role and assert independence	Resumes normal responsibilities	Rejects possibility or reality of recovery
↓ FREEDOM FROM SYMPTOMS			↓ FLIGHT INTO CHRONIC ILLNESS

bring the patient to the doctor are not always the same as the patient's presenting symptoms and that the doctor's assessment as a result may be incomplete or inaccurate. Besides a classification of the stages of illness (Table 1), therefore, he needs a simple method of categorizing factors which commonly precipitate a decision to consult.

Sometimes the patient's (or relatives') reasons for this decision are clear enough. The patient is unconscious; is prostrated with acute abdominal pain; is pale and sweating with pain in the chest; is sleepless with earache or an acute paronychia. In these situations the competent doctor experiences no difficulty: professionally he feels 'at home' with a crisis which requires technical knowledge and skill in intervention.

Nevertheless, even in situations where the symptoms are compelling, the time taken between a patient experiencing symptoms and reaching the decision to consult is extremely variable and influenced by much that is quite unrelated to the disease process as in the following examples.

Patient 1

Mr R. K., aged 50, had some mild "indigestion" after food and noticed on one occasion that his stools were black. At that time he was very busy at work (as a draughtsman), completing some drawings for a deadline. He was also preoccupied with the thought of his daughter's wedding in six weeks' time. He recognized that something was wrong but was "too busy to be ill".

His indigestion persisted, he lost his appetite, and started to lose weight. He and his family accepted that he was not well but did not want to spoil the wedding.

He continued to work, but with the agreement of his employer he took a week off work preceding the wedding as holiday. His wife bought him yeast tablets and stomach powders. He felt very ill at the wedding reception and afterwards went straight home.

It was at this point that his wife called the doctor who admitted him to hospital. There he was found to have a haemoglobin level of 7·2 gm per 100 ml, associated with a carcinoma of the stomach.

In less acute situations, where symptoms are not so compelling, the patient's response is even less predictable. His real reasons for consulting may be less obvious, and the reason he gives may be incongruous with what the doctor observes. Here, understandably, the doctor feels professionally much less comfortable and without some simple classification within which to work he may cast around ineffectually in search of the

reasons which have brought his patient to him.

Patient 2

Miss B. W., aged 23, a secretary with a responsible, well paid secretarial job, was a diabetic well stabilized on insulin. She attended her doctor twice yearly as a routine and was also seen periodically at the hospital diabetic clinic.

On this occasion she came with a three-week history of loss of weight and appetite, loss of concentration, and occasional blurring of her vision when typing. Examination revealed a loss of 1·35 kg (three lbs) in weight, a sitting pulse rate of 90, and a fine tremor. The fundi, visual fields, and acuity were normal; a fasting urine specimen showed the presence of ketones, with two per cent of sugar; and a fasting blood sugar was marginally above normal levels.

Since she was meticulous in testing her urine and understood the management of her diabetes well, the question arose as to whether she had adjusted her evening dose of soluble insulin in face of her symptoms? No, she had not thought it worthwhile.

This appeared incongruous to the doctor, so he adopted a different approach. The prime reason for her consulting then became apparent. A month previously, at the diabetic clinic, she had informed the doctor of her impending marriage and had (mis)understood him to say that, in view of her diabetes, she should not become pregnant. Not surprisingly, this had provoked a major emotional crisis. Her symptoms had followed.

What initially appeared to be a consultation precipitated by symptoms thus became one provoked by anxiety; and the therapeutic needs widened accordingly.

A working classification

Apart from patients who attend their doctor at his request, or for preventive care, or for administrative reasons, consultation is initiated either as the result of the patient's tolerance to symptoms, or to psychological or social stress, being exceeded. Trigger factors can thus be grouped as follows:

1. Limit of tolerance to:

1.1 Pain.

1.2 Other symptoms—e.g. breathlessness, cough, diarrhoea.

2. Limit of tolerance to stress

2.1 Psychological stress.

a) Primarily intrapersonal (ambitions, hopes, anxieties, fears, expectations).

b) Primarily interpersonal (family, work, or other associates).

2.2 Social stress: engendered by conflict, deprivation, change. As a result of poverty, social mobility, or chronic handicap.

In any individual consultation the doctor's understanding of the predominant trigger factors may of course change as his insight into his patient's problem increases. For example, when psychological or social stress present as physical symptoms, the doctor may start by categorizing the predominant trigger factor as 1.1 or 1.2 but subsequently revise this to 2.1 or 2.2 as the case may be.

Application

The doctor's attempt to understand the factors precipitating the consultation is but one aspect of his attempt to understand his patient. Their practical importance lies in the clues which they provide concerning both the nature of the problem and the nature of the person who has them, for example, the patient's insight into his problems, his tolerance of pain or other symptoms, his expectations (realistic or unrealistic) of what the doctor can achieve, his resilience and capacity for self help, the problems likely to occur in his rehabilitation, and so on.

Patient 3

Psychological and social stress precipitated this consultation for a well controlled chronic disease.

Mrs M. G., aged 61, an obese, diffident, and loquacious widow, had continued to live in her well-appointed council house after the death of her husband two years previously.

A year ago she had consulted the doctor on several occasions with pains in the neck and left shoulder, which had disturbed her sleep. X-ray had demonstrated a marked degree of cervical osteoarthrosis. Since then her symptoms had been well controlled with the periodic use of a collar and analgesics.

She now presented complaining of recurrent pain, which again disturbed her sleep, and requested different medication.

A number of features, however, aroused the doctor's curiosity about the aetiology of consultation. She was fidgety and ill at ease; pain was variably exacerbated by rotation of the neck; and her behaviour was at times incongruous—an animated description of her experiences on a recent pensioners' excursion was interjected into her account of tiredness and depression. On this occasion she had not used well-tried measures previously effective in controlling the pain but instead had come straight to the doctor.

Sensing that the consultation was artificial the doctor asked her directly why she had come.

Two weeks previously she had been notified by the local authority of its intention to move her into "more appropriately sized accommodation" on the fifth floor of a high-rise block of flats in an unfamiliar area of the city. The prospect was causing her considerable distress and she wanted the doctor's help.

Patient 4

This example demonstrates the limit of anxiety regarding others.

Mark, aged 10, the bright, alert son of intelligent parents, was brought by his mother with a two-day history of intermittent central abdominal pain, following a half-term trip to London. He had had no vomiting or diarrhoea but his appetite had been "scrappy" over the previous 48 hours. Physical examination showed nothing abnormal. Mark's mother readily accepted reassurance from the doctor but recalled that 12 months previously his sister had had acute appendicitis.

A classification of factors conditioning the response to illness

Patient 1 demonstrates how long a consultation may be deferred even where the need for it is clear and urgent. In terms of Table 1, the patient elected to remain in Stage 1 of his illness for several weeks. Though recognizing clearly that his symptoms were important

he chose to defer 'going sick' (Stage 2) and to delay seeking professional help (Stage 3). His reasons for this appear to have been his commitments to his work and to his family.

However, there are many other factors which similarly condition behaviour between patient and doctor. These conditioning factors can be classified in three broad groups:

1. Personal

a) The patient's perceptions of 'abnormality', and understanding of the importance of specific symptoms.
b) Emotional response to symptoms—apprehension, fear.
c) Previous experience of illness and disease.
d) Previous experience of medical care, and perceptions of the doctor's role.
e) Personal commitments to others.

2. Interpersonal

a) Accessibility, content, and perceived reliability of lay advice (from family, relatives, or friends).
b) Perceptions of abnormality and an understanding of the importance of specific symptoms within the social groups of which the patient is part.

3. Sociological

a) The 'folklore' importance attached to symptoms and to medical measures by society.
b) The 'mores' of society and their attitudes to specific diseases and illnesses (e.g. cancer, venereal disease, addiction to drugs).
c) The privileges and duties which are associated with 'going sick' by the society in which he lives.

Effects of conditioning factors

Since the effect of these conditioning factors is either to stimulate or to inhibit contact, they have a major practical importance for the doctor, for example by leading to: undesirable delay (or actual non-reporting) in illness and disease amenable to treatment; precipitate (unnecessary) consultations; non-compliance in treatment, or defection in follow-up; protracted dependence and invalidism; and a limited response to screening programmes.

The implications of 'going sick'

Parsons (1951) has suggested that in most Western societies 'going sick' is associated with two privileges and two duties. The privileges are:

1. That it is recognized that the 'sick' person is involved by an incapacity for which he is not actively responsible, and for which he needs help.

2. That sickness ('approved illness') is therefore a legitimate ground on which to exempt him, in part or in whole, from his normal responsibilities.

The duties imposed by society, if the sick role is to be approved, are:

1. That the sick person should wish to get well as quickly as possible.

2. That he co-operates with the competent professional help he has sought.

The patient, moreover, is not only aware of these privileges and duties but is also aware that the doctor accepts them. To commit himself to professional advice, therefore, is to commit himself to co-operation in what may prove to be unpleasant treatment, or risk rejection by the doctor.

Thus the patient's decision to consult (and his decision to comply) is rarely a simple one but is conditioned by a wide spectrum of factors. It carries an element of 'weighing the odds' and it is often useful for the doctor to have some idea of the odds that are being weighed.

References

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Effect of weight loss without salt restriction on the reduction of blood pressure in overweight hypertensive patients

Overweight patients with uncomplicated essential hypertension were followed up twice weekly for six months: 24 not receiving antihypertensive drug therapy (Group 1) and 83 on regular but inadequate (despite drug manipulation) antihypertensive drug therapy (Group 2). All patients in Group 1 and 57 randomly selected patients from Group 2 (2a) participated in a weight-reduction programme. The remaining 26 from Group 2 (2b) did not receive a dietary programme. Salt intake was normal in all three groups. All patients on the dietary programme lost at least 3 kg (mean, 10·5kg), and all but two showed a meaningful reduction in blood pressure; 75 per cent of Group 1 and 61 per cent of Group 2a returned to normal blood pressure. The reductions in weight and blood-pressure were highly significant ($P<0·001$), they occurred in both sexes and all ages, and were directly associated. In Group 2b there were no significant changes in blood pressure or weight ($P>0·30$).

Reference

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