

# Prescribing procrastination

GEORGE H. THOMSON, MD

Family physician, Rockford School of Medicine, Rockford, Illinois

**SUMMARY.** In his everyday work the family physician sees many patients whose problems have been diagnosed but for whom postponement of an active treatment plan is indicated. The physician must therefore prescribe procrastination in a carefully planned way. I describe some ideas and practical methods for doing this.

### Introduction

**P**ROCRASTINATION can be defined as 'putting off doing something until some time in the future'. It can be pursued passively either by postponing action or simply by ignoring the problem altogether. However, I suggest that the clinician can sometimes actively prescribe procrastination for the benefit of the patient.

Although the patient usually regards his or her problem as urgent, the skilled and experienced physician knows that it is often beneficial to the patient if the problem is allowed to 'rest' for a while. Managing this dilemma was described at one time as prescribing "tincture of time". I now suggest indications for such a prescription and the available ingredients.

### Indications for procrastination

Procrastination should be prescribed with the same intellectual thought and the same precision as for any other drug. The diagnosis must be as clearly defined as for prescribing penicillin for pneumococcal pneumonia or digitalis for heart failure. Handling uncertainty must not be confused as a system for managing the certain by prescribing procrastination.

The following are indications for active postponement:

1. When too early intervention by the physician is contraindicated. Often obstetrical dates are miscalculated and premature delivery is the consequence of failure to delay intervention.
2. When the patient's expectations of treatment are

different from the doctor's. Awaiting the localization of an abscess, a dying patient seeking a miracle cure, or a physician's watchful expectancy for the extrusion of a foreign body are examples of difference of expectations.

3. When intervention by the patient is contraindicated. Too early removal of fixation of fractures and vigorous local treatment of stasis ulcers merit management by co-operative inactivity.

4. When the patient believes that a self-limiting disease is serious. Pityriasis rosea, subsiding inflammatory lymph nodes, and vomiting in a healthy baby create anxiety for the patient or family which may be unrelated to the natural course of the illness.

5. Where time is needed for a more definitive diagnosis which can alter the prognosis and hence the goal of treatment. This is a common factor in the management of strokes and myocardial infarctions. It is also necessary in follow-up treatment of pneumonia and pulmonary tuberculosis.

6. Where inappropriate prescribing by the physician must be avoided. Antibiotic therapy for viral pharyngitis is a common example.

7. Where delay is required for reasons of good public or personal health. Healthy contacts of some communicable diseases are required to be quarantined as in smallpox. More often, however, patients recovering from common diseases must be protected from too early resumption of normal activity. This is especially true after chicken pox, influenza, and adult mumps.

### Methods of gaining time

When delay is indicated a number of different methods are available. No one method is invariably correct or invariably inappropriate. The choice depends on the nature of the patient, the effect on the family or other advisers, the complexity or lability of the disease, and the changing effects of time on the process. Therefore, rigid adherence to any one method may become inappropriate. The physician must be aware of all the available options, be able to use more than one at a time, and always be ready to alter his choice if need be.

When the doctor/patient relationship is good, education of the patient is the ideal choice. However, not all patients are equally educable, not all doctors are equally skilled, and time and disease alter the effectiveness of doctor/patient education roles. In the simplest of terms, the technique of education follows a set course. First is the establishment of the goal of the education followed by a description of the expected course of events. This should be followed by warnings of the effect of incorrect management and a chronological listing of the bench mark evidence of progress. Finally there should be a re-evaluation to prove that the goals were attained.

When the main reason for using the educational process is to postpone active management, this ideal series of events rarely produces the desired effect. Why? Impatience or rejection of the goal is the most usual reason for failure. The physician must concentrate on developing goals which are mutually understood and acceptable both to the patient and himself. This must be done by a method more complex than accumulating 'yes' and 'no' answers from the patient. Each essential attribute must be tested to determine that the required knowledge is mastered and secondly, each attribute must be tested in the context of belief. It is not enough to know that the patient knows he should await change—they must both know that he knows.

A common error in management by education is the assumption that the patient sitting in front of the doctor is the person to be educated. This is obvious when the patient is an infant. It is equally wrong to assume that the intermediary is the one to be educated unless he is also the medical decision maker for the family.

Co-operation in postponing action can be obtained by using a mutually agreed period of observation, the length of time depending on the patient's perception of the disease and its severity. Although this perception may be modified by education, patients often have a built-in acceptance time during which they will not pressurize the doctor for action, and this period can be lengthened by gentle persuasion. If the waiting time is to have any value the physician must involve the patient in the watchfulness, making sure that he understands it is important to the management of the disease and that the physician is really concerned about him. Therefore, the physician must arrange for appropriate follow-up visits and record both the patient's and the doctor's measurements of the parameters to be observed. It is imperative that the observation period must be understood by those who are supporting the patient at home or in the community as well as the patient himself.

Purposeful procrastination by use of laboratory and x-ray investigations is a commonly used strategy but is fraught with difficulties. Even if the physician believes that an objective test should be incontrovertible to the patient, the patient may not see it in that light. Forty-eight hours for a throat culture report is an ample delay while a viral pharyngitis subsides, but a falling sedi-

mentation rate or serum glutamic oxalo-acetic transaminase in a slowly subsiding phlebitis or acute hepatitis is a vague concept for many patients. The technique and value of a test must be explained to the patient, particularly in relation to his perception of his illness.

Using a non-therapeutic treatment or placebo as a delaying process requires the same caution as using laboratory tests. Laxatives have often been used for this purpose as have dye-containing urinary antiseptics, mild hypnotics, and tranquillizers, but the legitimacy of such an approach should be questioned by the physician and is increasingly being questioned by the patient. Unless the patient sees the effect as relevant to his disease, he may well stop co-operating. The use of the placebo effect in the context of delay is hazardous and rarely indicated. The use of a therapeutic trial may be indicated in the management of uncertainties in practice but is contraindicated when procrastination is the goal.

### *Functional testing*

However, functional testing is a valuable technique and one which is usually understood by the patient. The clinical entity being managed often has a built-in refractory period where mild stimulation as a test of maturity will either produce no change or will precipitate a desired progression which no longer requires procrastination. When this is explained to the patient, this test of 'ripeness' becomes a valuable method regardless of the outcome. If the functional test is followed by the desired change and the anticipated result, further delay is no longer needed and a new management plan can start. With proper 'priming' of the patient about the significance of an immature refractory period, a failure of the functional test will elicit his co-operation in delaying. The amount of time gained by the test should be agreed with the patient in advance. "If this test works, fine. If it doesn't, will you agree that the problem needs another two days (three weeks, two months)?"

There are many situations where functional testing is applicable. Adequate healing of fractures may be tested by eliciting distress on mild torsion or bowing of the fracture. Moderate stress testing is appropriate in some cardiac and pulmonary diseases. The minimal oxytocic effect of castor oil or vigorous physical exercise like housework or gardening have been used by women near term for years. In each case, the physician must be ready to manage the change if it occurs and the patient to accept the situation if nothing changes.

### *Other methods*

There is an almost limitless number of additional methods for procrastination which skilled physicians may use from time to time. They are often part of a planned strategy, but can also be used as the opportunity arises. Some patients present their own plans in the form of home remedies and old wives' skills. If these methods are deemed innocuous and humour the patient, they

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may well be used by the physician for their postponing effect. They certainly should not be scoffed at simply because the patient has such a firm belief in them. Consideration, quarantine, increased loss of work time, withdrawal of fitness certification, and the possible effect of exposure to other people might be used as added incentives for co-operative inactivity.

### Planned procrastination

However, by far the most effective tactic for the majority of patients is to have a plan of prescribing procrastination, which should be made up of a series of strategies, either running concurrently or applied in the following order:

1. Identify and use but do not misuse the delay period proffered by the patient.
2. Lengthen the time by educating the patient.
3. Involve the patient in co-operative observation.
4. Gain time by judicious use of investigation.
5. Gain more time if necessary by functional testing.

However, set pre-conditions must be observed before putting such a plan into effect.

1. The plan must be consistent with the patient's concept of the disease process.
2. The plan must be consistent with the patient's concept of the management of the process.
3. The patient must believe that the physician is really concerned about the problem.
4. The plan demands the inclusion and active support by the person in the family who makes medical decisions.

## Drinking patterns in patients attending seven general practitioners

Three hundred and forty-nine male patients whose ages ranged from 15 to 78 were interviewed when attending seven general practitioners in Glasgow. The study sought to review the drinking patterns in the east end of Glasgow and no attempt was made to select or exclude patients suspected of having an alcohol problem.

It was found that despite a high level of unemployment, overcrowding, and poor housing, a quarter reported spending £10 more a week on alcohol, and more than one in 25 spent more than £30 a week. According to Dight's category 18.6 per cent were defined as heavy drinkers. Over 40 per cent named beer or lager as their favourite drink, and half those interviewed drank only at weekends.

### Reference

Boothman, R. & Dunn, J. (1979). A study of patterns of drinking in patients attending seven general practitioners. *Health Bulletin*, 37, 51-55.