First do no harm: frequency of illness depends as much on family dynamics as on material factors

First Do No Harm” is a series of twelve brief monthly articles with internet footnotes about harming and healing in general practice. Each instalment is based on one of the 12 RCGP competency domains, this month’s being:


All diseases of high incidence may be said to have a “social” as well as an “individual” pathology.2

INTRODUCTION

GP’s are on firmer scientific and ethical grounds responding to symptoms brought to us by patients, we’re on shakier ground when it comes to biomedical surveillance of the population.4 We can’t avoid being involved in such surveillance, however, and can contribute in two ways. We can take account of psychosocial factors that, as much as biomedical factors, affect the health and behaviour of patients.1,5,6 And we can convey how benefit/risk equations change as we move from reactive care of consulting patients to pro-active care of the non-consulting general public.7 Symptoms have different predictive values, interventions have the same risk but less benefit, lead-time may lengthen morbidity but not longevity, benefit may be statistical rather than clinical, disease-specific mortality may be reduced but all-cause mortality unchanged, and — because of delay in benefit and immediacy of harm — some people die before benefiting.8,9

HARMING

Managing each episode of illness as an isolated event, being prolifigate with resources, prescribing antibiotics indiscriminately as much as biomedical factors, affect the health and behaviour of patients.1,5,6 And we can convey how benefit/risk equations change as we move from reactive care of consulting patients to pro-active care of the non-consulting general public.7 Symptoms have different predictive values, interventions have the same risk but less benefit, lead-time may lengthen morbidity but not longevity, benefit may be statistical rather than clinical, disease-specific mortality may be reduced but all-cause mortality unchanged, and — because of delay in benefit and immediacy of harm — some people die before benefiting.8,9

HEALING

Taking account of the antecedents, consequences, and ramifications of the consultation. Being aware of the interplay between individual and family.5,15 Seeking clinical, rather than just statistical, benefit.3 Providing palliative and terminal care.16

ATTITUDE

Having faith in humankind’s capacity for betterment while being sceptical, but not cynical, about how medicine can contribute to this.17

KNOWLEDGE

The family is a living and developing unit of interdependent members: frequency of illness depends as much on family dynamics as it does on material factors like hygiene, housing, and finances.2 The most frequently cited barrier to returning to work after a period of ill-health is anxiety.13

SKILLS

Finding out who’s with the patient in the consulting room (hello, I’m so-and-so, and you’re …?), in the waiting room (who came with you?), and at home (what do your family/friends say about this?), ensuring confidentiality I usually see patients alone for some of the consultation — can I ask you to sit outside for a few moments?1, ensuring the real patient.18 Using the seven ‘E’ questions to broaden the agenda of the consultation from the narrow biomechanical to the psychosocial.3

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Supplementary information

The internet footnotes accompanying this article can be found at: http://www.darmipc.net/first-do-no-harm-footnotes.html

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REFERENCES