Patient Study

A Patient Who Had Nothing Wrong With Him

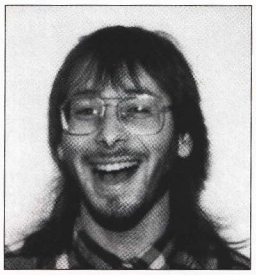
Mike Levin

S Afr Fam Pract
1994;15:576-9.

KEYWORDS
Physicians, Family;
Physician-Patient Relations;
Case Report

Summary

A medical student describes his experience with a patient. After a thorough examination and a full history, he felt he had reached the limit of the traditional medical method and out of desperation asked the patient what he thought was wrong with himself. Then the real problems were told. The student describes what it meant to him to discover the importance of listening, to stop interrupting with questions and allow the patient to tell his story his way.



Curriculum Vitae

Mike Levin is a final year medical student at UCT who intends doing internship at Cecelia Makiwane Hospital. He has been involved in SHAWCO, the student health and welfare organisation for many years and has a keen interest in Primary Health Care and Family Medicine. He also served on the Medical Faculty Students' Council in 1992 and various other student bodies. This is the first time he is being published and would like to say 'hi' to his family and friends!

40 Milton Road
Observatory 7925
Cape Town

Introduction

In medical school we all acknowledge that we are not equipped to deal well with patients who have no immediately obvious organic pathology. We are chosen, trained and prepared for high-action and sometimes heroic interventions, but have little training in dealing with patients simply as people. We are often warned of the dangers of reducing a patient to his or her diagnosis and of referring to them as "the liver in cubicle D", yet we are given little or no training or advice on how not to do this apart from our four weeks of family medicine. While in the block we pay lip service to "a holistic approach" and a "patient centred interview" without realising exactly what is involved. The skill of listening rather than doing anything is difficult for medical students to implement, as it necessitates us being passive rather than active. An opportunity to learn through being consulted by a patient who merely needed to talk, was presented to me during my visit to a community health centre.

Patient with nothing wrong

Mr Rashied Parker (pseudonym) is a 17 year old young man who presented to me with the complaints of chest pain, shortness of breath, lethargy and malaise. He also mentioned strange feelings in the extremities of his arms, and shakiness. The symptoms were all vague and atypical in nature, fitting none of the differential diagnoses I had in mind. A striking feature, however, was that the patient could say with certainty that all symptoms had appeared on a certain day of the previous week. I was suspecting that Rashied's physical symptoms were not due to underlying organic pathology, but I worked my way steadily through the medical history in its typical format, paying special attention to trying to be unthreatening and foster a good working relationship. I felt, however, that Rashied was not telling me all that he wanted me to know about his problem.

At the end of the history, I knew little about Rashied as a person. I knew he lived in a council house with his father and mother and had siblings who did not live at home. I knew that up until recently he had been a keen sportsman, that till last week he had had a steady girlfriend and that he neither smoked nor drank alcohol.

To put both Rashied and myself at ease about any underlying organic pathology, I proposed I do a full physical examination. I made it clear, however that I thought I would find nothing severely wrong and that we would talk some more after the examination. Rashied was a well built, fit young man who seemed markedly anxious. He made poor eye contact and had a severe tremor in both hands. He was somewhat edgy and restless and had increased sweating of the palms. His general examination was otherwise entirely normal and careful examination of the cardiac and respiratory systems revealed no abnormalities.

When I had finished the examination I realised that I had found nothing. Nothing on history, nothing on examination. Nothing. So, almost in desperation, I asked the patient a simple question: "What do you think is the biggest problem that is worrying you?", and to my incredible surprise received the answer: "There's nothing physically wrong with me, the only problem I've got is my family." My surprise stemmed from the fact that my thorough medical history and examination training had failed to help me discover why the patient was seeking help. It was only when I had reached the limit of the traditional medical method, when I asked a question out of intuition and genuine curiosity, that I managed to reach the patient's true concerns.

When I let Rashied talk, and stopped asking questions, I found out more about his family. During the previous week he had found out that his mother's husband was actually not his father. He discovered that his biological father was living in the same suburb as his parents and Rashied had gone to speak to his biological father who had spoken to him about his feelings towards his mother both in the present and at the time of Rashied's birth. This coincided with the time that his mother had married his step-father. He was confused and upset about the conflicting emotions this had engendered in him. He really liked this man as a friend, he had ties of blood with him, but also feelings of abandonment and rejection. He also felt robbed of the bond he should have had with this man.

We are trained and prepared for high-action, heroic interactions.

Little training in dealing with patients simply as people.

Difficult for a doctor to be passive and listen, rather than be active and always do things.

Concerning his step-father, he felt extreme anger at being deceived for so long, of being made to listen to and respect a man to whom he felt he had no ties any longer. His feelings towards his mother were even more confused. He felt angry at her for 'choosing the wrong man' and for lying to him as well. However, his clear affection for her seemed to result in him targeting most of his animosity towards his step-father. He perceived a difference between himself and his half-brother and half-sister and animosity stemmed from a jealousy that they both were brought up by their real parents.

Another important issue was that he was not yet old enough, he felt, to support himself and move away from the situation. He also felt he was not coping with his studying. He was not significantly distressed by breaking up with his girlfriend. He had broken up with her because he felt unable to talk to her about this new problem he was having. He had also not spoken to any friends about this.

With this background I was able to ask questions concerning anxiety and depression and found prominent symptoms of both. I discussed physical, stress coping and psychological options with Rashied who opted to see me again in a week's time rather than see a social worker, therapist or psychiatrist. He asked for 'pills to relax himself' in the interim. He also requested that I tear up my notes about his family and not reveal these details to the doctor from whom I needed to gain supervision for the prescription.

The three stage diagnosis was as follows:

1. Clinical

- anxiety disorder with somatisisation as symptoms associated with hyperventilation
- non-specific chest pain
- shortness of breath
- paraesthesias
- ? reactive depression

2. Personal

- confused about family situation
- would like to leave home
- believes he is not going to cope at college
- believes his problem is not physical
- will not accept referral to social worker, psychologist or psychiatrist or even another doctor

3. Contextual

- recent revelation that the man he thought to be his father is not his biological father
- meeting with 'real' father
- close relationship with mother who is supportive
- poor social support from friends or family

The next step was to formulate a plan that could deal with these problems. I felt I had already offered the most valuable intervention I could – the opportunity for Rashied to tell someone all the problems that were bothering him. I felt convinced, however, that further intervention would be necessary so I made an appointment to see Rashied in five days' time. I felt we had explored the problems well and formed a good platform from which to work together.

I told Rashied he should try to relax, play some sport, try some relaxation techniques and eat healthily and that next week we would look in more detail at these and other coping strategies. I felt I needed to research

At the end of the history I knew little about Rashied as a person.

Only when I had reached the limit of the traditional medical method...

Wanted to be brought up by his real parents.

these options and prepare more for our next session. After discussion with the tutor, we also prescribed a short five day course of benzodiazepines which we considered to be better than treatment with beta-blockers for the anxiety. It was also felt that the reactive depression was a much less severe problem than the anxiety and that treatment with anxiolytics would not exacerbate the depression.

Despite the fact that Rashied did not return for this follow up visit, I still feel that a valuable service was given to him. After discussion with various people, some doctors, some students of medicine and psychology, and some therapists, the consensus was that patients with deeper personal problems often present solely with physical symptoms. Clinicians often focus on these somatic complaints and never discover the underlying problems. I feel that for the first part of the consultation I had fallen into this trap.

The importance of listening well and of picking up on the patient's cues without missing those opportunities, became clear to me. I learned the importance of being silent, and listening fully to all the patient says and what he does not say. And the value of asking the patient the two vital questions "Why did you come today?" and "What do you think the problem is?" was also experienced.

I think Rashied could have benefited from further intervention. I like to believe, however, that the reason he did not return for further sessions, is not because he felt unable to, unlistened to or ignored, which was almost the case. Rather, I hope that the experience of being able to talk frankly, openly and without interruption had purged himself sufficiently to continue the process on his own to the stage where he would be able to experience relief from his problem and from his symptoms

Offered him the most valuable intervention I could: an opportunity to talk about his problems.

Reading List

Baron GS. Beyond the protocol: The potential of person-centred care. S Afr Fam Pract 1993;14:156-9.

Fehrsen GS. The person in comprehensive primary health care. S Afr Fam Pract 1993;14:404-8.

Furman S. Doctor, are you listening? S Afr Fam Pract 1990;11:281-3.

Lasich AJ. Common psychiatric problems encountered in general practice. S Afr Fam Pract 1988;9:266-71.

Levenstein JH. Patient-centrered general practice consultation. In: Course handbook.

Levinson B. Reclaiming the lost art of listening. S Afr Fam Pract 1993;14:11-4.

Mitton G. Stress management – an integrated approach. S Afr Fam Pract 1988;9:500-3.

Patients with deeper personal problems often present solely with physical symptoms.