Symptom Interpretation: The Crux of Clinical Competence – Joseph H Levenstein

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Curriculum vitae

Dr Joseph Levenstein graduated from the University of Cape in 1963 and joined his father in general practice in Milnerton. He has been actively involved in Academic Family Medicine for the past twenty years and is a foundation member of the Academy of Family Practice and is currently the National Chairman of the Academy. He is also Head of the Unit of General Practice at UCT and is convenor of the Faculty of General Practice of the College of Medicine of South Africa. He has published widely on many subjects relating to general practice which range from the management of ischeamic heart disease to the use of antibiotics in general practice and detection of colonic cancer. He has held visiting professorships at several universities in the United States and in South Africa and has been visiting Professor at the University of Western Ontario, Canada, on three occasions. In 1984 he was visiting Professor at the University of Hong Kong. Dr Levenstein was Vice-President of Wonca from 1978 until 1980 and actively represented South Africa on this body. He has received numerous academic awards, including the Louis Leipoldt Medal, Noristan Gold Medal and was the first recipient of the Lennon Boz Fehler Fellowship.

Summary

In the context of Family Medicine, the symptom on its own is meaningless and has no objective reality; thus the competent GP would understand his patient, rather than interpret his symptoms. The author refers to a few surveys done in this field and to the differences in the two dominant models of medicine in his attempt to propose, explain and formulate a distinctive family medicine method which adheres to the principles of a scientific model. The need for such a model whereby the discipline of Family Medicine could conduct its process, is emphasized.

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Any "debate" on clinical process, with general practitioners as participants, will not produce a major philosophical conflict as few will argue with the contention that we are principally involved with the management of people rather than pathologies. However, one of the major impediments to the advancement of our discipline is the tendency to explain it in the terminology of traditional or biomedical medicine. We describe our method or process in terms of a scientific model that is inappropriate to most of our activities. In so doing we say the "Symptom interpretation is all important". However, we qualify this contention by maintaining this is so *"only if"* we take into account the personality, the defence mechanisms, the culture and the psycho-social circumstances of the patient — not to mention the doctor's personality and attitudes as well as the relationship that exists between doctor and patient.

In other words, compared to the specialist disciplines, we maintain that we have a unique way of "interpreting" so-called symptoms. In fact, these *"only ifs"* are the crux of the method of our discipline, and consequently our clinical competence rather than symptom interpretation per se. Method is central to any scholarly or professional discipline. In order to function within the framework of that discipline, its method or process must be adhered to. In medicine, this includes an accepted systematic procedure for the gathering of information and the rules needed for classifying and validating that information. As medicine is a scientific discipline, its method must adhere to the principles of a scientific model or paradigm.[1]

Newtonian physics and symptom interpretation

The statement "symptom interpretation: the crux of clinical competence" is derived from the

Note: 1. Paper delivered at the 12th WONCA Conference held in Israel – 1989 in debate form at a plenary session in which Dr Levenstein took the con position.

2. This paper appears by kind permission of "The Family Physician" of Israel.

Newtonian scientific paradigm which does not nearly explain the clinical process which family physicians utilise in their continuing care of unique patients with undifferentiated problems which are a complex mixture of physical, psychological and social factors.[1] Newtonian physics would maintain that a symptom is an objective reality.

Understanding the patient rather than interpreting his symptoms

Furthermore, that it has an objective identity and a meaning of its own. A further tenet of this paradigm is that the observer of these symptoms (ie the doctor) is objective as well. Thus, any number of doctors, with equal knowledge and skills given a set of symptoms, regardless of the patients from whom they emanate, should come to exactly the same interpretation or diagnosis.

Newtonian physics would further insist what happens between the observed and the observer does not alter the experiment, ie the doctor-patient relationship is irrelevant. Now, none of us believe any of this.

Einsteinian physics and symptom interpretation

I would maintain that symptoms emanate from subjective patients, the meaning of which is unique, only to them, that the doctors who interpret these are far from objective and that what happens between patient and doctor, ie the doctor-patient relationship, does affect the experiment.[1]

These tenets are consistent with Einsteinian physics which has applicability to most of the activities of Family Medicine. Einsteinian physics furthermore, explains the world in terms of relationships rather than reducing it to the smallest possible particle.

Recently we have labelled the method associated with traditional Newtonian medicine as "doctor-centred" and that of Family Medicine as being "patient-centred".[2,3,4,5]

Before proceeding any further, I would like to make it quite clear that this contention does not invalidate the contribution made by disease or doctor-centred medicine but merely attempts to explain the family physician's perspective of medicine in the understanding and managing of illness.

Symptoms and patients

Symptoms are signs or indications of illness. In presenting a symptom, patients are translating into words their interpretation of how they feel.

There are two ways in which symptoms are attributed to patients. Firstly, there are the symptoms which patients present spontaneously and secondly those which we elicit from them by systems review.

We are involved with people rather than with pathologies.

With regard to the former, it stands to reason that the same symptom verbalised by different patients may represent a variety of feelings.

The symptom of "giddiness", for example, may mean of multitude of things to a multitude of patients.

In a study which I conducted in my practice, I asked 30 consecutive patients who spontaneously stated that they were "giddy", and that giddiness was their main problem, what they meant by the term. The response was illuminating: only 6 described vertigo, 9 were "light-headed", 6 felt "unsteady" and the remaining 9 had other explanations.

Our method must adhere to the principles of a scientific model.

It is interesting to reflect on the ultimate agreed upon principal diagnoses of the patients' giddiness. They were Meniere's Syndrome (2) ear infection (4), uncontrolled hypertension (4), side effects from medications (6), anaemia (2) (one due to Bronchiogenic Carcinoma), 8 had viral infections and the remaining 8 patients' giddiness was associated with feelings related to psycho-social disturbances such as marital disharmony and syndromes such as depression and anxiety. Obviously there are more than 30 diagnoses, because, try as both patient and I did to attribute one diagnoses to their giddiness, occasionally two were thought possible.

Thus it is abundantly obvious that in the Family Medicine context the symptom on its own, is meaningless and has no objective reality.

If we look at the status of symptoms elicited by systems review, the

significance of the symptoms on their own is even more meaningless.

The highly defended patient says "no" to the possibility of any symptom and the highly anxious patient has every symptom you suggest to her/him. Allow me to conduct an exercise which I do with all my students. This consists of asking a series of directive questions. I would like you to answer them as I proceed:

Do you get headaches?
Are you short of breath?
Do you get stomach pains?
Do you have any muscular pains?
Do you fight with your parents?
Are you short of money?

As expected, they are bewildered yet the more anxious ones say "yes" to most and the defended ones say "no" to most. In other words, there is a consistency to their answers, almost regardless of the question.

We attempt to analyse what unconsciously must go on in one's mind when answering such questions.

Explanations offered are: "What does he mean by headaches?" Of course I get them, but I can handle them so

Symptoms are feelings of patients translated into words

that's why I answered no, or I do get them occasionally, maybe it can be serious, that's why I answered yes.

With shortness of breath, all want to know "relative to what?" "Should I be able to climb three flights of steps or more?" . . .

It must be realised that systems review evolved in the attempt to diagnose and manage patients with established disease. It thus stands to reason that the question, "Are you short of breath?", addressed to a patient sitting up with the help of six

The same symptom verbalised by different patients may mean a multitude of different things.

pillows might have the same frame of reference to the observer and the observed. However, there are no established criteria as to what constitutes dyspnoea in undifferentiated ambulatory patients.

A substantial portion of the class answer, as do patients, ambiguously with words such as "sometimes", "occasionally", and "not really". In effect they are cueing the doctor to state what he means and are hoping for more discussion on the subject.

So it would appear that a spontaneously offered symptom can be as a result of differing feelings and sensations of patients and elicited symptoms are more reflective of patients personalities and their defence mechanisms than they are of objective medical reality.

The exercise is further highlighted by integration and interpretation of the answers. For example, one can say "I understand why you get headaches and tummy pains because you fight with your mother and are short of money!"

There is a further complicating factor where patients either consciously or unconsciously don't offer symptoms, some of which can be highly significant. Denial mechanisms are powerful. For example, a stated reason for a visit can be a medical examination, when a patient has retrosternal pain and a fear of coronary artery heart disease. Conversely, there are the patients with a multitude of symptoms which would be impossible to interpret without involving a dozen diagnoses. In the former instance, we have no symptoms to interpret and the latter too many. Yet both situations have unique meanings to each patient which have to be understood for effective diagnosis and management.

This is not the end of difficulties that are encountered by accepting symptoms, as objective medical realities. Symptoms are inevitably associated with fears and feelings. These in fact can be the major components of the illness.

It is rare to find a patient who does not have fears associated with symptoms. These again are unique to the patient.

For the GP the symptom on its own is meaningless and has no objective reality.

How they perceive the fear will determine the vigour they pursue medical attention and the frequency of visits. They may present again and again with an array of symptoms, trying to get fears met. Either they may embroider on an initial symptom or offer new symptoms.

Likewise the feelings associated

with symptoms can be a predominant part of the illness or one of its constituent parts.

Thus, I would maintain that the crux of clinical competence in family medicine is not the interpretation of symptoms but rather the understanding of the patient and the reasons for his or her attendance.

Models of medicine

The two dominant models of medicine are thus the traditional biomedical Newtonian, (or the doctor-centred model), and the holistic, biopsychosocial Einsteinian (or patient-centred) model.[6]

In the former, the doctor attempts to interpret the patient's illness in terms of his own explanatory framework. The interview is dominated by the doctor who, it is assumed, has all the necessary knowledge and skills — the individual patient's participation is almost irrelevant. The objective is to fit the patient's illness into a precise classification linking the symptoms and signs with organic pathology and identifying single external causes

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Patients who were allowed by their doctor to express their feelings were more satisfied and compliant.

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such as micro-organisms. The power of the doctor-centred reductionist model needs no explanation as to its effectiveness in the diagnosis and exclusion of clearcut organic disease.

Symptoms have thus an objective status and their interpretation may well be the crux of clinical competence.

In the patient-centred model the doctor sees each patient as a unique individual with a unique illness. He endeavours to enter and "tune-in" to the patient's world and facilitate the expression of his illness and the perceptions of illness. The doctor, furthermore does not place a value judgement on the patient's illness, recognising that whatever its nature, it is causing pain and anxiety to the patient. Bearing in mind the multi-causal factors of illness, he listens carefully to the patient and attempts to enter the patient's world using empathy, non-judgemental acceptance and congruence. It is accepted that the doctor cannot be patient-centred unless he is aware of self and his attitude and behaviour are appropriate to such an approach. (Balint's seminal contributions to our discipline are universally acknowledged).

In this model the symptom serves as an introduction to the clinical process.

General practice model

The lack of a distinctive model for general practice hampers the progress of the discipline in several ways. For example, as general practitioners are using different models, it is understandable that morbidity studies in the discipline are often at great variance with one another.

Furthermore, in the teaching of the discipline, the absence of a model makes the learning, teaching and evaluation of the consultation extremely difficult and the wide variation of trainers' models makes the exercise highly subjective. We therefore have to resort to the Newtonian model to explain our method. It is obvious that both models have relevance to general practice. However, the most important objective of any interaction and therefore the crux of our clinical competence, is to establish the reasons for the patient's attendance — the components of his illness. In

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Clinical competence rather than symptom interpretation

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the short time available, attention must be paid to detail of the patient's presentation, since all that he says, and does, and does not, in this concentrated time (which has perhaps followed days or even years of indecision), must surely be relevant. The reason for his attendance can be expressed in terms of his "expectations", his "feelings" and his "fears".

Every patient who seeks help has expectations explicit and implicit of the doctor. Furthermore, he has feelings related to his illness which can be the result of several factors. Although fears are feelings, they are such a universal component of illness that they are given a separate heading.

The doctor can facilitate the expression of the patient's reasons for attendance or he can "cut-off" the patient. This can be effected by ignoring him or failing to take up what he is expressing, both verbally or non-verbally, thereby ignoring the context of the patient's presentation or repeatedly rejecting what the patient is trying to communicate to him.

Formulating a model for family practice

Family medicine must have an agreed upon model whereby it conducts its process. It must be flexible enough to allow for several styles but nevertheless it must have identifiable components that allow for comparison. No longer can we accept that "anything goes". How can we be sure of content and intervention and outcome if our clinical processes differ?

In my attempt to propose a model for the Family Practice interaction, to understand patients and their reasons for attending, I was determined that it should be valid to our discipline. In the past, too many attempts have been made to create something which never existed. By this I mean in our desire to obtain credibility, we called upon endless experts outside of the discipline to tell us what we should be doing, ie what Family Medicine should be, rather than to systematically examine what it was, ie what we were doing.

To this end, I audio-taped about 1 000 of my interactions to try and tease out what I was doing instinctively and unconsciously. Thereafter, I was able to construct my simplistic tabulation of doctor and patient agendas, patient's expectations, feelings, fears and prompts, doctor-facilitating behaviours and non-facilitating behaviours — "cut-offs".

Much research has been undertaken on this model at the Family Medicine Department of Western Ontario in order to validate it, teach it, and measure whether patient centredness has any effect on outcome.[3,4,5,7,8,9,10,11]

There are two outcome studies directly related to this work:

Firstly, a study of 140 adult patients with a combination of chronic illnesses and self-limiting conditions visiting 24 family physicians, found that patients expressing feelings were more likely to be satisfied and compliant 10 days later than those not expressing or not so encouraged by their physician.[7]

The second study on outcome examined 73 adult patients with one new symptom visiting six family physicians.[8] It showed that high scoring consultations (on patient centredness) were related to:

1. Decreased patient concern about the presenting symptom;
2. Patient's perception that the presenting problems were fully discussed;
3. Patient's perception that his/her reasons for visiting had been fully understood by the doctor.

Symptoms are inevitably associated with fears and feelings.

This evidence of a relationship between patient-centred communication and patient perceptions after the visit, is supported by recent studies by others showing significant associations of patient-centred visits with patient recovery and physiologic outcomes. Most strikingly, Greenfield, Kaplan and Ware have found patient-centred elements of interviews to be related to blood pressure control, diabetes control and peptic ulcer resolution.[12,13]

Canadian examples of such studies include Bass et al,[10] who have shown that the resolution of the patient's symptoms was associated with physician-patient agreement about the nature of the problem. Also, the Headache Study Group found that headaches were more likely to be resolved at one year if the patient felt he had an opportunity to discuss the problem fully at the first visit.[11]

Obviously, this is the beginning of trying to formalise, unify and prove what we all already know and believe of Family Medicine. However, until we have an agreed upon language, method, taxonomies and classification, we will make the error of describing and debating our activities within a framework which is inappropriate.

It is thus argued that it is far more scientific and apposite that the crux of our clinical competence is understanding the patient and not symptom interpretation.

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