The patient's concern

- "the second diagnosis"

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Curriculum vitae

Mxolisi Mankazana graduated from the University of Natal. After a spell at the Charles Johnson Memorial Hospital at Nqutu, he set up general practice at Flagstaff in Transkei where he worked for several years. He has been in London since 1976. He studied for the DTPH at the School of Hygiene and Tropical Medicine of the University of London. Subsequently he has served in the St George's Hospital, Community Health Services as Community Physician in Child Health for the Borough of Wandsworth.

Summary

It is argued that "the patient's concern" needs to take precedence over the doctor's agenda in the clinical interview, especially at the primary health care level where the approach in health care delivery is more person-oriented than disease-orientated. Yudkin's notion of "the second diagnosis" is explored and developed. The doctor's knowledge about the patient's cultural background and his language is essential for effective communication between the doctor and his patient. Some of the skills necessary to deal with "the patient's concern" are described and a demonstration of their application during the interview of four patients is presented in the form of transcripts. It is suggested that such skills can be taught to medical students and reinforced at the post-graduate level, particularly during the envisaged period of medical vocational training in South Africa.

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Clinical experience at the primary health care level suggests that a substantial number of patients present with symptoms which do not readily fit into an organic diagnosis such as "wonke umzimba" (whole body) where the symptoms affect all systems of the body with the spread of symptoms not consistent with any conventional pattern. Failure to find a suitable label for the patient's symptoms then presents a difficulty in understanding in professional terms. A preparedness by the doctor to explore the symptoms *through the eyes of the patient* may help to reduce this difficulty.

My personal experience at medical school was that medical training did not adequately equip me with the communication skills vital to help a patient further explore his symptoms. I seem to have been sensitised mainly into a more interrogatory style, using mostly closed-ended questions and a tendency to show some impatience whenever symptoms were volunteered which did not seem to be of immediate relevance to the professionally perceived problem at hand. Such behaviour seemed to spring from the fact that I tend to work from a frame of reference which required that the patient's illness fitted a predetermined pattern of symptoms. Similar observa-

tions have been made concerning doctors during the medical consultation.[1] I do not think I was encouraged enough to develop the skills of enabling patients to disclose, explore and come to terms with some of their anxieties or to consider that the symptoms may be an expression of the underlying emotional problem. Other doctors too, seem to have had a similar experience during their medical education.[2] Having identified these shortfalls in my training, I set out to improve my communicating skills with patients. I endeavoured to change my style of consultation from being predominantly mechanistic to being more person-orientated.

Yudkin[3] talked about the notion of a "second diagnosis" in his paper on the management of six children presenting with cough. I have found it necessary to develop his notion somewhat further.

Definitions

Good clinical medicine[4] basically consists of making an accurate diagnosis, planning the treatment programme, and establishing the kind of doctor-patient relationship which will encourage compliance with treatment. The diagnosis made by the clinician only can accurately be defined in scientific terms. This could be called the *first diagnosis*. However, quite frequently, the patient (or in the case of a child, the mother) may attach his or her meaning, association or fantasies, to the illness. Her understanding of what is happening involves primarily her feelings, "Listen to my concern, please doctor" and at times has strong suggestions as to what could be done to manage the illness perceived. This could be called *"the second diagnosis"*.

The *"second diagnosis"* can tell us:

1. What the patient's main fears and frustrations are: "Dumile is not getting better even though he was given Aunt Madlamini's famous herbal inhalations";
2. The patient's fantasies (her understanding of the origin of the disease, and the nature of the illness);
3. The patient's expectations in coming to see the doctor (what she wants him to do for her);
4. Why the patient has come to see the doctor *now* (what are sometimes called Zola's triggers)[5];
5. How the clinician can help the patients help themselves.

Communication skills should be taught to medical students

As we shall see later (for example Patient 1), even when the traditional clinical diagnosis has been made, *"the second diagnosis"* would need to be addressed before the help offered is complied with.

It may be important to acknowledge the patient's concept of his illness before it is explained away and shown not to provide a plausible explanation for his disease (for example Patient 2). I would like to believe that this may have been one of the reasons for poor compliance by TB patients under my management and care in the Transkei[6].

It needs to be pointed out that the problem orientated medical record (PROM)[7], expresses the patient's subjectivity about his/her illness only as perceived by the doctor, while *"the second diagnosis"* would claim to go further and furnish some information about the circumstances surrounding the illness episode as well as the psychological impact of the illness on the patient. Furthermore, PROM[8] addresses mainly the problem of data collection, storage and easy retrieval as well as digestibility of data in general practice.

The emotional content in patients is demonstrated mostly by non-verbal cues

Harrison's textbook[9] on the Principles of Internal Medicine, and indeed Fletcher[10] as well, mention the importance of the inflections of the voice, facial expression and attitude, as clues to the meaning of the patient's symptoms, but say nothing about how to acquire and use the relevant skills to get such information.

How can the doctor develop his ability to recognise *"the second diagnosis"*?

Firstly, he needs to have a high level of awareness and to tune into all the channels of communication[11] available in the clinical setting ie verbal communication which tells us mainly the factual content, extra-verbal (imparts mainly the mood or affect), unverbalised phonation (reveals the emotional content) and the non-verbal forms or body language (show the emotional content and mood). Experience in interacting with patients, teaches us that whenever the verbal and non-verbal messages contradict each other, it is the non-verbal form which expresses the true message.

Secondly, to develop the appropriate skills to recognise *"the second diagnosis"*. Such skills are listening, reflecting back, appropriate style of intervention during the diagnostic[12] and therapeutic phase of the consultation. Thirdly, the attitudes of the doctor or his understanding of the helping relationship, how he sees his role in this relationship and how willing he is to accommodate the patient's fantasies and his felt needs.

A year's course on Patient Communication[13] helped to change my style from being predominantly busi-

ness-like and authoritative, to being less overpowering, giving precedence to the patient's agenda, allowing a free-flow by the patient in expressing his concern as he saw and understood it and being more perceptive to non-verbal cues.

What follows are transcripts of consultations, obtained by memory recall one to two hours after the interviews, to illustrate perceptiveness to the "second diagnosis".

Patient 1

This is a young mother of 23 with 2 children. The delivery of her first child was followed by a period of post-natal depression. The first child experienced poor weight gain during the first year of life. On this particular morning her younger child, now aged 5 months was found not to be gaining weight well. The health visitor to the family had tried to advise her on infant feeding, but to no avail. The mother and child are then referred to the community physician in child health to exclude any organic basis for the poor weight gain and for further advice.

Doctor (D1): *Good morning Mrs Patel. Would you like to have a seat? Is there anything the matter with you today? You look a bit sad!*
Mrs Patel (P1): *My baby is not putting on weight well. I have tried almost everything to stop him bringing up his feeds.*
D2: *Are you saying that he brings up every feed?*
P2: *He brings up about 2-3 feeds a day.*
D3: *And this is every day.*
P3: *Almost every day, and nothing seems to help to stop it (gesticulating with her right hand).*
D4: *This seems to be causing a lot of worry to you.*
P4: *Do you remember Paul? (first child). I saw my doctor last week.*
D5: *So you got some help from the family doctor?*
P5: *He gave me some medicine but it did not help.*
D6: *Are you saying that the medicine he gave you did not make any difference?*
P6: *I do not think anything can help (shaking her head) because this is due to bad mucus she swallowed when she was born.*
D7: *Are you saying that the mucus is still there?*
P7: *The hospital doctors tried to remove it, but a lot of it was left behind.*
D8: *So you think that it is this mucus which is the cause of your baby's tummy upset and not putting on weight well?*
P8: *I think it is the mucus that stops the food from staying down.*
D9: *I can well understand your worry when you were told that your baby had swallowed a lot of mucus. But swallowed mucus does not cause vomiting in later life.*

There followed a physical examination.

D10: *There is nothing seriously wrong with your baby. If you look at the weight chart she gained well between 3 weeks and four months. Some babies do have some tummy upset when introduced into a solid diet. She will settle down as Paul did. I can recommend some medicine, Gaviscon, which is usually good at stopping this kind of tummy upset.*

The following three months the weight picked up from below the 3rd percentile for age to above the 10th percentile due to acceptance and compliance with treatment.

Comments

The interview lasted 10 minutes. The mother's concern was the excessive mucus which she believed was swallowed by the baby during delivery. I had little difficulty in accommodating her mythology, but later became confronting and told her it could not be the cause. My concern was whether this poor weight gain was eventually going to lead to failure to thrive, which may need secondary referral. I was able to pick up her sadness and communicated such awareness to her. Being perceptive to her mood and checking it with her at the right time, enabled her to talk freely about her own concern, and made her not to feel inhibited in expressing her fantasies (*her* understanding of what her baby's feeding problem was due to).

An ability to cope with silence can help the patient to change over to another area of concern

Patient 2

A Ghananian lady brought her 8 month old baby for developmental assessment.

Doctor (D1): *Good morning Mrs Ayola. Would you like to sit down? I see here that your baby is now 8 months old. We usually play some games with them at this age to see if they are growing up well. You look worried about something today.*
Mrs Ayola (P1): *Why does she still have a big hole on top of her head? The older children did not have that hole when they were so big.*
D2: *You speak as if you are worried that that there may be something wrong with her head.*
P2: *Do you think that her brain is safe when there is such a big hole on top of it?*
D3: *Are you saying that her brain may come to some harm when she has such a big hole?*
P3: *Don't you think that germs can easily get into her brain?*
D4: *Would you like me to have a look at her?*

There followed a developmental assessment and physical examination which revealed a large anterior fontanelle but with normal size head and no separation of the sutures.

D5: *Everything seems to be alright. She is growing up well. She can see and hear well. All children have this 'hole' you mentioned but with different sizes. In due course, however big it may be now, it will close; probably at 15 to 18 months of age. You are not the only mother who has been worried about this 'big hole', but knowing why it is there, makes most mothers less worried about its presence.*

Comments

My professional need was to make sure the child was developing well, but quite clearly the mother's concern was different. I allowed her anxieties about her baby's head to dominate the interview, reflecting back her own feelings surrounding the problem. I appreciated her fantasies about this hole and consequently I was able to reassure her in more specific terms. I was also picking up the worry on her face and confirming this with her, which made her able to speak freely about her concern.

Patient 3

This is a 12 year old Caucasian schoolboy from a single parent family. The school is worried about him because of school refusal and disruptive behaviour in class. I have seen Mark for medical check-ups regarding his cardiac pace-maker after his physics teacher was concerned about the possible danger from magnets in the laboratory.

Doctor (D1): *Have a seat, Mark. There seems to be something bothering you today, Mark. You do not look very happy!*
Mark (P1): *I did not sleep well last night. I was up until late looking for my sister.*
D2: *Were you on your own while looking for her?*
P2: *My mother was driving around with me looking for her.*
D3: *For one moment I was not sure whether it was the school situation that makes you unhappy.*
P3: *I do not get along well with most of the teachers except the English teacher.*
D4: *Are you saying that because you do not get along well with most of the teachers, you are unhappy?*
P4: *I do not like the teachers in London.*
D5: *In London?*
P5: *Well, we used to live in Deal in Kent, and then moved to London so that I could be near to Guy's Hospital because of my pace-maker. In Deal I used to get along well with the teachers and I had a lot of friends too. I do not like London. I miss the countryside (at this stage Mark was noticed to be wringing his hands and his lips became dry).*
D6: *There seems to be something else worrying you now Mark!*
P6: *I have not had my check-ups in the hospital for about a year now. I am worried about my weak heart.*
D7: *Have you told anybody that you are worried about your heart?*
P7: *I told my mother and she promised to arrange an appointment for me, but nothing came of it.*
D8: *You feel that your heart is still weak.*
P8: *I feel very tired every day. I used to go out jogging in the mornings in Deal, but now I can't. I always feel worn out when I wake up in the morning.*
D9: *And you feel this tiredness is due to your weak heart.*

P9: *I think my heart is getting worse. I am getting weaker. I am not supposed to be near magnets or anything with a pulling force on the pace-maker. I would like to live near to Guy's Hospital in case my heart stops. But I hate living in London.*

(A period of silence; about 30-40 seconds).

I enjoyed the countryside. We made our own swings, played games of soldiers and I had about 5 friends in Deal.

D10: *Are you saying you do not have many friends in London?*

P10: *I find it difficult to make friends in school. They make me angry, and I then walk out of school or go to the matron's room.*

D11: *So you walk out of school.*

P11: *Sometimes I have stayed away from school. I did that at the beginning of the term and wandered around Tooting Broadway Shopping area.*

D12: *So you would like me to get an appointment for a check-up. About helping you to have some friends in your class, I will speak to the Matron and the Head of year, Mr Marshall, who may move you to another class where the boys are more friendly.*

(Then followed a physical examination).

D13: *Your heart is fine today.* (Pause a few seconds.) *I notice that this is making you feel happier. But I do agree that I need to arrange for a check-up at Guy's as you have requested. I will also arrange with the Physical Education teacher to enable you to be let off any strenuous activity until you have been seen in hospital.*

Comments

The interview lasted 20 minutes.

My concern was to establish whether his medical condition could explain adequately his school absence so that I could give the appropriate advice to the school. Mark's concern was not just his heart. He seemed to be saying "Tho' I live in London (physically), emotionally I live in Deal. How can my heart function well when I have no friends and am generally unhappy with the teachers? I have played truant because I am generally unhappy in London as a person. Could I possibly go to Deal, the countryside I love and was happy in?" Listening and reflecting back was helpful to enable him to talk freely about his anxieties, his fears, and his unhappiness without any fear that I would pass some judgement on him as a person.

Patient 4

I am asked, as the School Medical Officer, to see the father of a 12 year old boy with a poor record of school attendance. My agenda was to exclude any medical reasons for school non-attendance and ascertain whether there may be some collusion by the parents. Both the boy and his father were interviewed, but separately.

Doctor (D1): *Come in, Mr White* (doctor on his feet). *Would you like to have a seat? I am the school medical officer and have been asked to talk to you about your son. You look anxious about something today!*

Mr White (P1): *Richard is in a lot of trouble with the school and the teachers.*

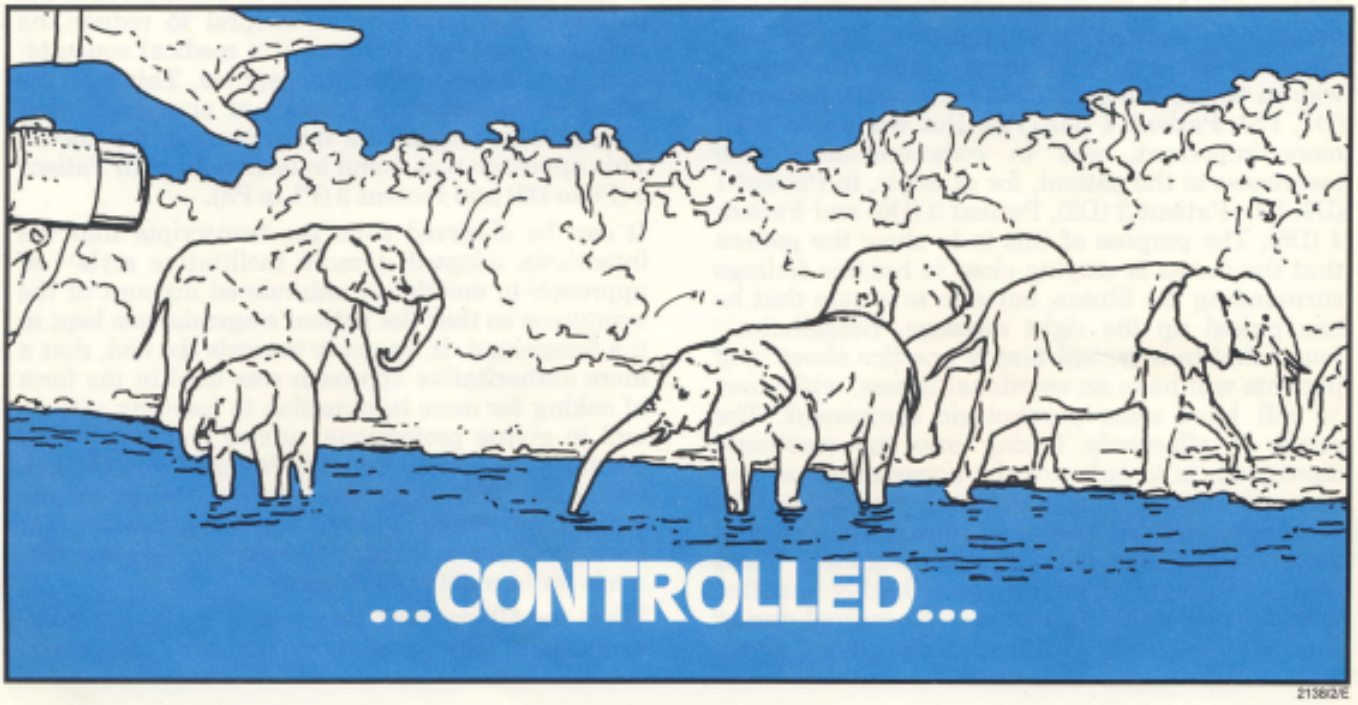
D2: *A lot of trouble, did you say?*

P2: *Yes, he has not been coming to school lately.*

D3: *Not coming to school?*

P3: *He is in the company of bad boys.*

D4: *You do not seem to like the company of boys he associates with.*



P4: *Well, you see doctor, he has been dodging school without my knowledge.*
D5: *Without your knowledge?*
P5: *A man from the Education Office came to see me at home because Richard is dodging school* (His facial expression changes and he has a serious look).
D6: *Did this visit by this official upset you then?*
P6: *Yes, I gave Richard a good telling after that.*
D7: *A good telling?*
P7: *More than that. I gave him a good hiding. He will not do it again, I am sure.*
D8: *Has he been unwell lately?*
P8: *A few tummy aches and sore head.*
D9: *A sore head?*
P9: *Nothing serious, the wife gave him some disprins.*
D10: *You and your wife are in good health, though?*
P10: *There is nothing the matter with us.*
D11: *Richard has not dodged school in the past, I take it.*
P11: *This is the first time he has done it.*

The boy is called in but he is not prepared to say anything. Physical examination was non-contributory.

Comments

Picking up his mood non-verbally and letting him become aware about such observations, and also using the technique of reflecting back, enabled this man to talk freely about his son's poor school attendance. He felt free to go further and told me that he has now remedied the situation.

Discussion

The emotional content in patients was demonstrated during these clinical interviews. This was achieved by being perceptive to the non-verbal and verbal cues emitted by the patients, for example, Patient 1 (D1, P3, P6), Patient 2 (P1 – the forceful way in which she made this statement), Patient 3 (D1, P5), Patient 4 (D2, P5). But what was even more important, was in communicating such awareness to the patient, for example, in Patient 1 (D1, P4), Patient 2 (D2), Patient 3 (D6) and Patient 4 (D6). The purpose of this is to show the patient that the doctor is staying close to her/his feelings surrounding the illness, but also to ensure that he has picked up the right message. Boekelheine[14] found that in a typical family practice about ⅕ of patients will have an emotional illness, while over ½ will have some psychologic component. The result of effectively tuning into the emotional dimension, is to enhance the communication process and content, thereby enabling the achievement of compliance with treatment prescribed. Patient 4 demonstrated this. Korsch and Negrete[15] found that, of those mothers who were highly satisfied with the communication that had occurred during the interview, over ½ followed the advice given, while with those in which satisfaction was poor, only ⅙ complied. Pietroni[16] also found that in two consultations lasting 2 to 3 minutes, where the same words were used by the doctor and the patient, the disparity in satisfaction was attributed to the ability or inability to tune into the emotional dimension.

The ability to detect the emotional component (anger, sorrow, anxiety, sadness etc) can further be enhanced by the technique of reflecting back. This skill was used in all the interviews, for instance, Patient 1 (D2, D3, D6), Patient 2 (D3), Patient 3 (D4, D5, D9, D11). This technique also helps to avoid the unnecessary use of closed-ended questions which may hinder free flow in expressing symptoms. Mokhobo[17] suggested a similar approach during medical history-taking among South African Blacks.

The ability to cope with silence can be helpful to enable the patient to change over to another area of concern without being prodded to do so. During the interview with Patient 3, there was a period of silence of about 30 to 40 seconds (D9). When he resumed speaking, he moved into another area of concern ie not having any friends in this present school.

Accommodation of the patient's fantasies will help to make the consultation more relaxed and open

A deliberate attempt or action to accommodate the patient's fantasies can be helpful to reduce the rather formal environment of a medical consultation, to a more relaxed atmosphere. This has the effect of engendering a spirit of acceptance and unconditional regard for the patient by the doctor. This approach was found to be helpful with Patient 1 (P6 to D9) and Patient 2 (P1 to P3).

It can be observed from the transcripts that the interviews adopted a more facilitative style[18] of approach to enable an unhindered account of the symptoms so that the patient's agenda was kept in the foreground. It was only towards the end, that a more authoritative approach was used in the form of asking for more information to meet my agenda and in giving professional advice and prescribing treatment as seen at D9 with Patient 1 and D5 with Patient 2. This style also made it easier for the patient to make known his expectations, for instance Patient 3 came to have an appointment made for him at Guy's Hospital.

What the Ghananian lady meant by "a big hole" was readily understood by me because I understood

her culture and what made her perceive the anterior fontanelle as such. Boekelheine[19] reported that cultural, educational and social differences (similarities) between the doctor and the patient can constrain or enhance effective communication due to their effect on both verbal and non-verbal language. Other workers too, Zola[20], and Mokhobo[21] found that a knowledge of the patient's ethnic background and culture and language can be helpful in the clinical interview.

Tuning into *"the second diagnosis"* is very essential for those at the forefront of primary health care where one of the main aims is to be patient- or person-orientated, rather than disease-orientated. Yudkin[22] goes further, "a doctor who practises without learning the local myths and language is practising with blinkers and misses a great deal which his patients tell him". It therefore becomes essential to ensure that the appropriate communication skills are imparted at some stage in a doctor's career, especially that such skills are not mentioned during the clinical teaching at the undergraduate level.

The need to address the patient's concern need not be limited to the primary health care level. Some consultants have found that even at the secondary and tertiary care level, listening and accommodating the patient's concern is helpful in dealing with patients. Surgical patients in a large hospital, where doctors had taken account of the patients' anxieties and powerlessness in the hospital setting, (double blind experimental design used) needed a lower dosage of analgesia post-operatively[23]. My personal experience in the Transkei in general practice was that with post-hysterectomy patients from secondary and tertiary referral hospitals, much as the operation was a technical success, not much was done before the operation to enable the patient to explore her anxieties concerning her future sex life. Many of them developed sexual symptoms (frigidity, dyspareunia etc) sometimes ending with the breakdown of the marriage. The patient's concern was different from the doctor's agenda.

It has been observed that medical students demonstrate some inability to clarify the real nature of the patient's complaints being "reluctant to ask about relevant psychological and social aspects of their history, and failure to pick up verbal and non-verbal cues"[24]. Experienced general practitioners have learnt consciously or otherwise, to recognise non-verbal cues and respond to them for the establishment of an empathetic interview. Most, when asked, will reply that you either have got it or haven't, and no teaching will give it to you[25]. Frequently this goes unchallenged. Maguire and Rutter[26] suggested that much of a practical nature could be done to help medical students and doctors improve their history-taking skills, and they went on to show that a programme they devised (using matched pairs) was more effective in equipping medical students with the appropriate communication skills, than the traditional training methods. The issue then arises whether the training to acquire the necessary verbal and non-verbal skills of communication is best included in the undergraduate medical curriculum, during the internship year or after registration. The highest proportion of doctors in South Africa are general practitioners, most of whom are in the vanguard of primary health care. It is essential that such doctors are trained to acquire the necessary skills to communicate effectively with their patients, and not to wait for them develop these skills intuitively. Vocational

training, as suggested by Silbert[27], may be the appropriate time for such communication skills for newly or recently qualified medical graduates to be imparted. For those already in general practice, who are willing to acquire such skills, weekend or day release courses held in the medical schools, or regionally, may be an option to be considered.

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