THE HIDDEN AGENDA AND DIAGNOSIS IN GENERAL PRACTICE

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ABSTRACT

Diagnosis in general practice involves more than the diagnosis of a physical illness. An important objective of a general practice consultation is to understand the hidden feelings and fears of the patients. Seven case reports are presented to demonstrate the need to go beyond the physical diagnosis and to identify the hidden agenda in order to make a comprehensive biopsychosocial diagnosis of the patient's problems. A good bedside manner is more than good manners. It is an essential ingredient of the diagnostic process in general practice.

Keywords: Hidden Agenda, Diagnosis, Compliance, Problems of Living, Sick Role.

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INTRODUCTION

"From inability to let well alone;
from too much zeal for the new
and contempt for what is old;
from putting knowledge before wisdom,
science before art, and cleverness before common sense;
from treating patients as cases,
and from making the cure of the disease more grevious
Good Lord, deliver us."

The Litany of Sir Robert Hutchinson
(1871 - 1960)

Every patient who seeks help from a general practitioner has some expectations of his doctor and feelings and fears about his problem. Some of these expectations, feelings and fears may be explicit but a large part may not be. An important objective of a general practice consultation is to understand as much as possible these expectations, feelings and fears, in particular the hidden ones.

A hidden agenda is often present in a doctor-patient encounter. With the emphasis on technology, this has become less obvious and more difficult to detect. As a doctor turns more and more to machines, his basic intuitive human abilities decline and the skill to recognise the hidden agenda is correspondingly diminished.

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With the latest medical advances and breakthroughs, both doctors and patients tend to focus their attention on physical disorders for which there appears to be a cure. Consequently, there is an increasing tendency for the doctor to pigeon-hole a patient's problem into specific physical disorders. The focus on physical diagnosis results in a failure to address hidden expectations, feelings and fears that are paradoxically heightened by the attention given in the lay press to medical advances.

The Biopsychosocial Diagnosis

Discovering why the patient came is not the same as making a physical diagnosis. An illness is a complex experience that may not be captured by a single diagnostic label. Diagnosis in medicine is also not as easy as it appears. It is even more difficult in general practice when there are often very few physical signs. For example, it has been found that 20 to 84% of patient visits to primary care are for somatic complaints that have no organic diagnosis[1]. It is this group of patients that requires considerable skill and years of experience in general practice to establish a close rapport with the patient and to acquire an awareness of the hidden agenda.

To diagnose a physical disease, a doctor needs only an organised schema which he regards as having an independent reality[2]. But in order to make a biopsychosocial diagnosis, a patient-centred general practitioner has to be concerned with everything that influences how information is perceived, interpreted, symbolised and acted on by the doctor or the patient[3]. The following cases are presented to highlight the need to go beyond the physical diagnosis and to identify the hidden agenda in order to make a comprehensive diagnosis of the patient's problems.

CASE REPORTS

Case 1: *The Patient Who Does Not Want To Get Well*

Mr A, a 56 year old male is a long-standing patient suffering from hypertension and gout. He is on a beta-blocker, a calcium antagonist and allopurinol. His hypertension was not very well controlled and rangec from 130/90 to 160/110. In spite of being advised to gc on a diet, Mr A remains obese.

His hypertension does not worry him as it does not produce any symptoms. His frequent visits to the clinic are prompted more often by acute attacks of joint pains. These attacks are precipitated by alcoholic and dietary excess.

Mr A is a manager. He is not ignorant of the effects of dietary excess on his obesity, gout and hypertension as his doctor had explained to him the need for dietary restrictions and the importance of his diet on the control of his medical problems. Yet he chooses to ignore the doctor's advice and remains a heavy social drinker and a lover of all meats and seafood. He indulges heavily and his job allows his plenty of opportunities to do so.

He strongly believes in enjoying life while he can and does not believe in punishing himself with a spartan diet. He is sceptical of doctors and medical treatment and even feels that he is actually healthier than most doctors. In support of this conclusion, he cited both his siblings (a brother and a sister) who are doctors and are in much poorer health than he is.

The disdain with which he dismissed his siblings as useless professionals who could not even take care of their own health suggested a deep sense of inadequacy or even resentment. It was felt that his poor compliance with medical treatment and advice may in fact be a manifestation of deep-seated resentment. This conclusion was reinforced by the knowledge that the patient had entered medical school and dropped out. In the light of such background information, the general practitioner deduced that the patient was using the consultation as a displacement of his hostile feeling. Focusing on the gout and hypertension will leave both the doctor and the patient frustrated.

We tend to assume that all patients see a doctor because they want to be healed. But many general practitioners will have encountered patients, like the above patient, who do not want to be healed and who, in fact, are out to prove that they cannot be healed.

CASE 2: *The Trauma of Amenorrhoea.*

Madam B, a 37-year old housewife consulted because her period was two weeks overdue. Her menses had been delayed before but never this late.

She has a seven year old daughter and was worried about being pregnant. She cited age and financial considerations for her desire not to conceive.

She had a pregnancy test done at another clinic a few days earlier and the result had been negative. She was however unconvinced and wanted another opinion.

A pregnancy test was then repeated and the result was again negative. In spite of repeated reassurances that the test was fairly reliable, Madam B remained unconvinced and almost sceptical. Instead of being relieved, she appeared more anxious and wanted to know the reason for her amenorrhoea.

This led the doctor to probe further into her emotional state. However, she denied being depressed, unhappy or under stress on direct questioning. She expressed her scepticism that these feelings could not have any connection with amenorrhoea. The doctor then asked her if she have had some shocking experience that she might not have been aware of. After a long period of silence, she suddenly broke down and cried uncontrollably.

When she managed to control herself, she disclosed that she had indeed just undergone a very traumatic experience. Over a week ago, her husband who was a fishmonger met with an accident in which a fishing hook went into one of his eyes. When she went to the hospital all the doctor did was to tell her, in what she felt was gory details, of the surgery that the husband had to undergo. She did not know what was going to happen to him, what his future and the future of his family would be like. And she began to cry again.

In this difficult hour, Madam B needed someone to understand her, to reassure her and to clear the mist of confusion and fear clouding her mind. This can only be done if the hidden agenda is recognised.

This case is an example of a heterothetic presentation. In this heterothetic help-seeking behaviour, the patient consults the doctor with a minor symptom, but the real motive for seeking help was the underlying emotional difficulties which were hidden.

Case 3: *The Breast Lump That Was Not Mentioned*

Miss C was a staff nurse of many years' experience. She saw the doctor, complaining of epigastric pain. On examination, she was not in distress and nothing abnormal was detected. From non-verbal cues, she did not appear sure of her symptoms nor comfortable in giving the history and seemed almost to be making it up.

The doctor then terminated the consultation by writing out the prescription. He mentioned that her condition could be related to some other problems she might have. On this verbal cue, Miss C hesitantly asked whether the lump in her breast that she had discovered recently had anything to do with it. With this revelation, the consultation took a more satisfactory course.

Many patients like Miss C have a hidden agenda when they see a doctor and it is necessary to go beyond the presenting complaint and physical diagnosis. Symptom reporting is a subjective thing and what is reported may not reflect accurately the illness experience of the patient.

Before a person can report his symptoms, he has to undergo three stages. Firstly, he has to feel a change in bodily sensation or feeling state. Secondly, he has to recognise these changes as evidence that something is wrong. Finally, the significance of these symptoms are interpreted in the light of that particular individual's life situation.

The meaning of a symptom may vary in different individuals as the meaning behind a particular illness may have a symbolic meaning, shaped by special cultural beliefs; personality and previous life experiences[4]. For example, it is a common experience in general practice to have a patient requesting for a check-up because a friend just died suddenly or a girl complaining of giddiness and epigastric discomfort when she is actually worried about pregnancy.

Case 4: *The Child As The Presenting Symptom*

Master D was a 13 month old baby brought by his mother Madam E, a 41 year old educated lady, to see the doctor complaining of cough and running nose for one day. There was no fever and examination revealed no nasal discharge or crepitations in the lungs. The child was as normal as any child could be.

Master D's condition could have been managed symptomatically and the consultation ended with a

general reassurance for the mother. However, Madam E's concern for her child was totally out of proportion to his presentation, particularly as this was her third child. Moreover, she had a sister who was a staff nurse staying with them.

On exploring her anxiety, it transpired that Madam E had a husband who was an asthmatic. Six months ago while at work, the husband had a sudden, severe attack of asthma and died on arrival at a hospital. Being the sole breadwinner, the demise of her husband created a financial crisis. To compound her emotional difficulties, her in-laws had not only been unsupportive but had considered her the curse that had resulted in her husband's death.

Since the tragedy, Madam E had been overtly anxious and any cough or running nose in her children would cause her to fear thar it may lead to a fatal asthmatic attack.

She was in fact the real patient and her expectations, feeling and fears needed to be addressed as the child's problems were only the mother's "ticket" for the consultation.

In this case the child is the presenting symptom and the hidden agenda is the mother's previous traumatic experience of her husband's fatal asthmatic attack. It would have been disastrous to dismiss the mother as being neurotic and try to assure her that the child was only having mild asthmatic bronchitis!

CASE 5: *The Woman With Infertility And A Jealous Husband*

Madam F, a 34 year old clerk, complained that her period had been delayed for one day. On her first visit to the doctor, she was accompanied by her husband. She also had nausea and giddiness.

She expressed anxiety over her inability to conceive since she stopped her contraceptives two years ago. She also said that she had pressure at work and also had to coach in her schoolwork her 7 year old daughter whom she described as "naughty".

As it was too early to determine the course of action for her. a general discussion on fertility took place and she enquired if the husband should go for a sperm count. However, the husband did not share her enthusiasm nor her anxiety, and remained totally detached throughout the consultation.

One week later, she returned to the clinic alone. Her period still had not and come and she wanted a pregnancy test. This was done and the result was negative. She appeared relieved but at the same time asked to be referred for investigation of her secondary infertility.

The general practitioner detected an atmosphere of ambivalence to this whole episode. He shared with her his observation that she seemed to have some difficulties with her life. She denied having any problem and claimed to be a very happy-go-lucky person. However, after some reflective listening,the patient lowered her defences and admitted she was having some problems. Her boss with whom she had worked for over ten years had been a very detached person. Lately, he had some marital problems and had suddenly become extremely good and warm towards her. This sudden change in the boss' personality had made it difficult for her to do her work properly and had also made her husband jealous and caused some disruption in her relationship with the husband.

After ventilating her problems, the patient did not press for further investigation and three months later she conceived.

CASE 6: *The Patient Who Carried His Family Burdens On His Back*

Mr B, a 39 year old male taxi driver presented with sorethroat and backache with numbness over his left buttock. He is married with two sons. He attributed his pain to his work as he had to sit in the taxi for long periods of time.

When asked about the kind of bed he has, he disclosed that he normally sleeps on the floor as his two sons sleep on his bed. As he was staying in a three bedroom flat, the general practitioner enquired further and found that his father, who had a stroke one year ago, was staying with him. The other room was occupied by his mother and his sister who was separated from her husband.

As a result of the family's heavy financial commitments, the patient had to work long hours. The general practioner then commented that the patient seems to be carrying a heavy load. This gave him an insight into his backache and he confessed that he felt very burdened to the extent that he felt "frightened" whenever he gets into his taxi.

The above two cases illustrate the point that behind the presenting complaints may be problems of living which many patients face. A high proportion of patients in general practice present with psychosomatic disorders in which the causative role of the problems of living can easily be elucidated. Unfortunately, the hospital approach to diagnosis and treatment is based on the biomedical model of illness and often ingnores the psychosocial factors involved in the pathogenesis of disease[5].

CASE 7: *The Wife With Dysmenorrhoea And Sexual Conflicts*

Ms H is a 40 year-old married factory worker with 3 children aged 15 to 20 years. She was seen for recurrent pain in the left iliac and epigastric pain for four years in a government hospital and by her general practitioner. She also complained of dysmenorrhoea. She had an appendicectomy nine years ago.

The gynaecologist found no significant abnormalities except for "slight tenderness" over the uterus and the utero-sacral ligaments. A laparoscopy was subsequently done and she was found to have a slightly enlarged uterus with very small myomata and two endometriotic spots on the posterior lower wall of the uterus opposite the rectum.

In the hospital she complained of severe epigastric pain associated with backache and vomiting. However, gastroscopy, CT scan and barium enema were all normal. She was then treated with danazol for her endometriosis.

Subsequently she saw her general practitioner for backache and abdominal pain and disclosed that she was taking danazol. On reviewing her case notes, the general practitioner found that five years ago, he had made a note to check on her sexual history as her youngest child was 11 years old and she was not on any contraception.

The general practitioner then felt that sexual dysfunction may be the real reason for the patient's complaints and contacted the gynaecologist about the diagnosis of endometriosis. The latter disclosed that the two endometriotic spots were in fact very small and that the danazol was given as a therapeutic trial. The gynaecologist subsequently obtained a history of marital problems in a detailed interview on her next visit.

When she saw the general practitioner at a following visit, the patient disclosed that she was having quarrels with her husband over sexual intercourse. This was confirmed when the husband was interviewed during another visit. It became obvious that the patient was trying to use her illness to justify her avoidance of sexual intercourse when she tried to get her doctors to tell her husband that she cannot have sexual intercourse because of the endometriosis.

The above patient is an example of patients who need to legitimatise a sick role. It is important to recognise the tendency of patients with chronic pain or illnesses to adopt the sick role. The secondary gain of being sick includes avoiding social commitments, sexual intercourse and having an apparently legitimate reason to avoid whatever is displeasing to the patient. Such sick role behaviour can quickly become a way of life[6].

DISCUSSION

Our medical training is orientated towards making diagnoses and prescribing drugs for symptomatic treatment. Such an approach tends to blind doctors to the hidden agenda of the patients.

The crucial skill in making an overall diagnosis, defined by Balint as "an understanding of people in a professional capacity" is to be receptive to cues which the patient gives verbally or non-verbally. The ability to listen to what is not said as well as the non-verbal cues is essential for the first phase of problem definition, which is discovering why the patient came. This art of listening is not only a skill that can be taught and learnt but that needs constant practice.

The Diagnosis In General Practice

Medical advances have given us a fantastic amount of knowledge about the physiology, pathophysiology and aetiology of diseases. This has led to the tendency to see the patient like a rundown motor car in need of spare parts (transplant surgery) or repairs (reparative surgery). The art of medicine is reduced to the mechanics of performing a few tests to make the diagnosis, and then to apply the appropriate treatment.

But man is more than the engine of a motor car. He is the driver as well who can be affected by many other factors such as the family, work, friends and other social factors. Unfortunately, the specialist knows more and more about the car but less and less about the driver. It is the general practitioner who is in a better position to see the damage that the driver inflicts on the car and also how the car can give the driver a headache.

With a specialist and hospital-based medical education there is a tendency to focus only on those aspects of the patient's problem which are the easiest for the doctor to handle. Consequently, many doctors fail to recognise underlying psychosocial problems as they are too busy chasing a physical diagnosis and asking the patient a barrage of questions. Instead of allowing information to flow freely from the patient, the doctor is cutting off the patient with very specifically-directed interrogations. Such an approach results in an imposition on a frustrated patient the doctor's own agenda and views instead of an understanding of the patient's agenda and his views on health and illness.

The Patient-Centred Approach

General practitioners are in the best position to observe the close and intricate relationship between physical illness and the inner disharmony of the mind and the emotions. With an awareness of such a relationship the management of minor illnesses will be seen from a different perspective. It is then not simply a matter of coughs and colds but as Dr. Bernard Lau, a psychiatrist in Hong Kong pointed out:

"A family physician then becomes well-placed to observe and influence family interactions by virtue of his ongoing contact with families. Handling a trivial complaint in a member of the family may ultimately turn into management of the psychopathology of the family in trouble, which is even more challenging, rewarding and satisfying than routine dispensing of trivial complaints"(7).

General practitioners therefore have the important task of seeing the patient as a human being who has a body, mind and soul rather than a rundown motor car in need of repair and spare parts. In order to do so, it is necessary to cultivate good bedside manners. It is sad that the bedside manner is dismissed as simply a personality trait or common sense or "mumbo-jumbo."

Dr David Mendel noted that an essential ingredient of "proper doctoring" is the much maligned bedside manner and made the following observation:

"The best doctors acquire one over the years, but many never do. I think this is due to the usual overswing of the pendulum. Around the turn of the century, medical remedies were not very effective: in the circumstances the bedside manner was all there was.

Now that we can cure many diseases, both doctors and public have replaced the wise avuncular physician of the past with the 'intensive care whizz kid image.' We don't need all that mumbo-jumbo when we have proper scientific methods, they say "(8).

A good bedside manner is more than good manners - it is an essential ingredient of the diagnostic process in general practice. It is the adoption of a patient-centred attitude that will enable the general practitioner to recognise and address the hidden agenda of his patients.

The patient-centred model has been described by McCracken et al as a powerful teaching tool as they have seen students change their styles dramatically after even only a day's of concentrated exposure to the precepts of patient-oriented medicine (9).

The diagnosis of the disease process in a patient may be entirely impersonal but the understanding of the patient as a human being with an illness requires an empathetic personal relationship.

CONCLUSION

When the hidden agenda is not recognised, patients may be exposed to lengthy diagnosis and expensive therapeutic interventions. What we get in the end is not excellent health care but a group of frustrated patients who needs have not been met, hopping from doctor to doctor.

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