Why do dyspeptic patients over the age of 50 consult their general practitioner? A qualitative investigation of health beliefs relating to dyspepsia

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SUMMARY

Background. *The prognosis of late-diagnosed gastric cancer is poor, yet less than half of dyspeptic patients consult their general practitioner (GP).*

Aim. *To construct an explanatory model of the decision to consult with dyspepsia in older patients.*

Method. *A total of 75 patients over the age of 50 years who had consulted with dyspepsia at one of two inner city general practices were invited to an in-depth interview. The interviews were taped, transcribed, and analysed using the computer software NUD.IST, according to the principles of grounded theory.*

Results. *Altogether, 31 interviews were conducted. The perceived threat of cancer and the need for reassurance were key influences on the decision to consult. Cues such as a change in symptoms were important in prompting a re-evaluation of the likely cause. Personal vulnerability to serious illness was often mentioned in the context of family or friends' experience, but tempered by an individual's life expectations.*

Conclusion. *Most patients who had delayed consultation put their symptoms down to 'old age' or 'spicy food'. However, a significant minority were fatalistic, suspecting the worst but fearing medical interventions.*

Keywords: dyspepsia; gastric cancer; over 50s; consultation.

Introduction

IN the United Kingdom (UK), gastric cancer accounts for 10 000 deaths per year, primarily in those over the age of 50 years.[1] Five-year survival is as low as 5%, principally because of the advanced stage at which many patients are diagnosed.[2] Much of this delay occurs before patients consult their doctor.[3] Although dyspepsia is a very common symptom,[4] 65% of sufferers do not seek medical advice.[5] Consultation behaviour has been examined from both psychological and anthropological perspectives.[6,7] According to the health belief model,[8] consultation is determined by cues, perceived seriousness, perceived vulnerability, and the balance between costs and benefits.[9] Patients may conduct 'lay' consultations and construct a complex personal view of their symptoms before consulting a doctor.[10] Zola[11] identified five influences as to whether patients consult: the availability of medical care, whether the patient can afford it, the availability of non-medical therapies, how the patient perceives the problem, and how the patients' peers perceive the problem. 'Triggers' may also be required.

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Previous studies have suggested that 'stomach disease' is most commonly linked to stress and worry, patients being most concerned with finding causal life events to lend individual relevance to their symptoms.[12] Jones and Lydeard[13,14] interviewed both consulting and non-consulting dyspepsia sufferers to explore psychological traits, life events, and beliefs about dyspeptic symptoms. There was no difference in the frequency or subjective severity of symptoms between the two groups,[14] but consulters had more life events and were more likely to believe that their symptoms were caused by serious illness, and cancer in particular. A more in-depth qualitative approach to the subject may be of value in determining why many older patients consult late with symptoms of potentially serious upper gastrointestinal disease.[15,16] The aim of this study was to construct a model to explain why patients over the age of 50 years diagnosed as having dyspepsia consulted their GP, using qualitative methodology.[17]

Method

All patients over the age of 50 years consulting with dyspepsia (including acid reflux, peptic ulcer, duodenal ulcer, heartburn, and gastritis) in the previous three months were identified and invited by letter to attend an interview at two practices that electronically recorded all encounters. The interviews were conducted at the practices by the author, taped, and transcribed. Patients were told that the interview was 'to find out their views about the causes of indigestion symptoms and to find out what made them come to see the doctor'. The sample size was by saturation; interviews were conducted until no new themes emerged. The most fruitful data were obtained by discussing previous episodes of symptoms about which the patient had not consulted and exploring key differences in symptoms, beliefs, and other factors.

Analysis

The transcriptions were analysed using the computer software NUD.IST (Qualitative Solutions and Research Ltd, Victoria, Australia). The text was coded and examined to establish relationships between the themes, seeking plausibility, contrasting explanations, and moving from the particular to the general and back, in line with Glaser and Strauss's grounded theory.[18] The reliability of the interviews was maintained by being conducted by the same interviewer using a semistructured proforma. The methods used to establish validity were seeking refutability and plausibility,[19] analytical induction (developing a theme or a relationship in one case and then sequentially seeking its presence in others),[20] and respondent validation.

Results

Subject characteristics

A total of 75 patients were identified as eligible for interview and invited to attend. Altogether, 31 interviews, average length 30

minutes, were carried out. No further computer searches were required as, by this stage, no new themes were emerging. The average age of the patients interviewed was 64 years, and there were 16 men and 15 women.

Qualitative analysis of the transcribed interviews

Three main themes were established, with further subdivision into categories as shown in Figure 1.

Theme 1: Reasons for consulting with dyspepsia

Category 1: Perceived threats. The possibility of a cardiac origin to the pain was of concern to many patients.

> *'I thought it was probably from the heart, I don't know what heart pain is like, but when I felt the pain there I began to think all types of things.'*(9)

(Numbers in parentheses indicate code number of the respondent.) Peptic ulcer disease was mentioned in the context of medical investigations or serious complications and the pain being worse than 'just indigestion'.

> *'I thought there was something seriously wrong — I thought I'd got an ulcer and you hear such a lot of things about ulcers bursting and whatever….'*(3)

Personal and family histories of peptic ulcer disease featured strongly.

> *'I remember my dad saying that the pain (when he had an ulcer) started there and met round his back.'*(20)

Fear of gastric cancer was mentioned as a reason for consultation by many patients, prompted by the presence or character of the dyspeptic pain, often in association with a sensation of a 'lump'.

> *'I thought of (cancer) because I get pain in my stomach sometimes and I've heard that people with cancer have a lot of pain in the stomach.'*(24)

> *'I think it would have been a week or two before I came in…. I was frightened of cancer.'* (5)

Category 2: Seeking reassurance. Some patients were at pains to mention that they were not worried, but the symptoms were troublesome enough to seek help, explanation, and being seen to 'do the right thing' by consulting the doctor.

> *'It's something that will get better in its own way and when it didn't I thought "lets go and see what the doctor has to say about it."'* (20)

Category 3: Cues. Evidence was found to support Zola's[11] triggers, the severity of symptoms, interference with social life or

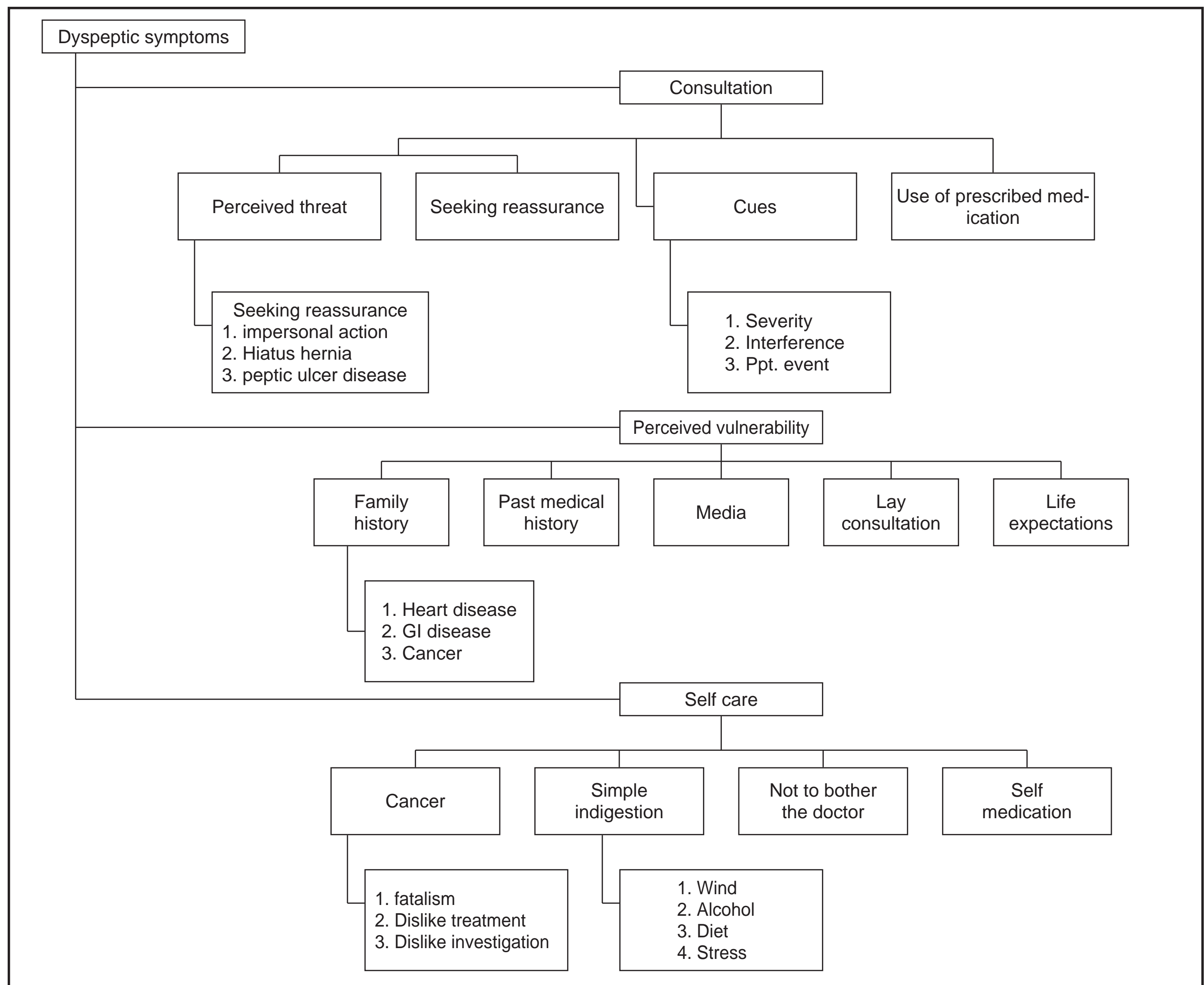

Figure 1. Relationship between themes.

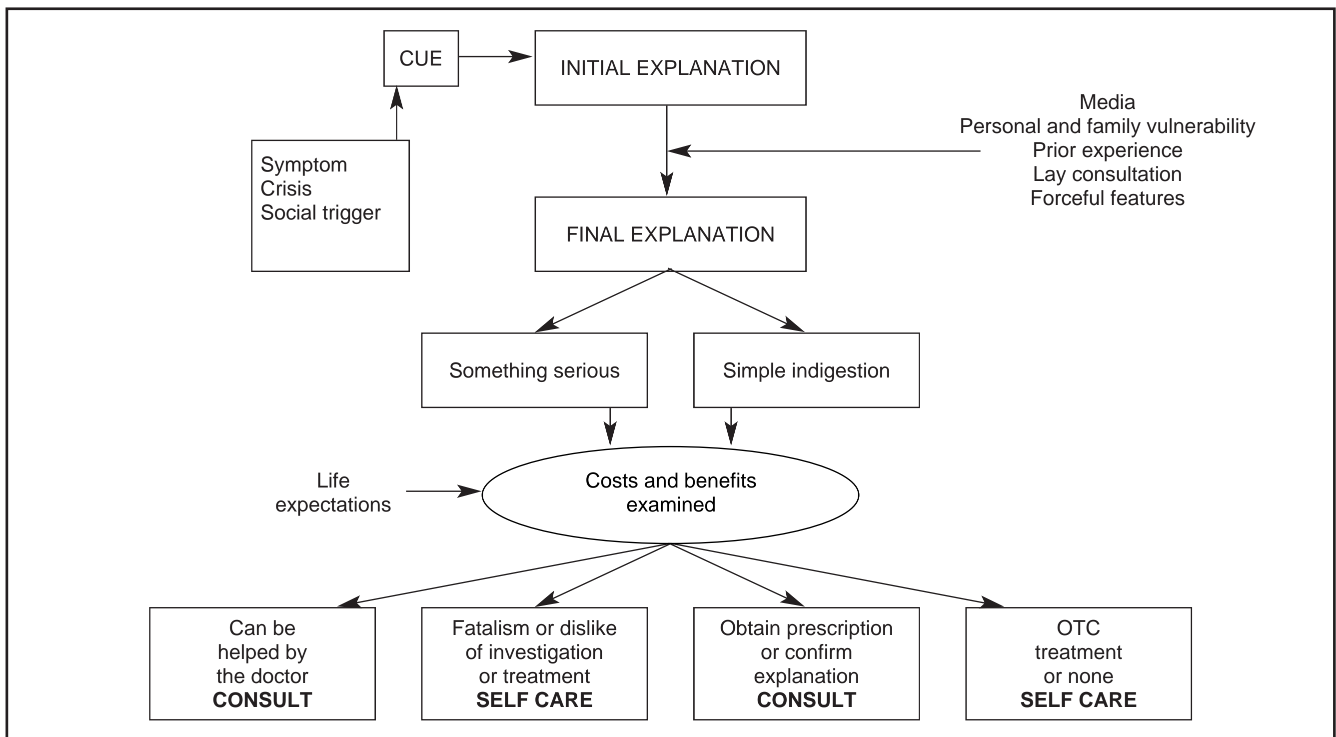

Figure 2. Explanatory model of why patients consult with dyspepsia.

work, and interpersonal crises.

> *'It was in the days when my son died, I thought it was an ulcer because you don't know what's happening to you...'*(14)

For many patients, a sudden increase in the severity of symptoms had led to a re-evaluation of what had previously been put down to simple indigestion. Such events often happened at night.

> *'The first night I suffered it all night long, the second night when it happened I thought I'm calling the doctor out.'* (22)

Category 4: Use of prescribed medication. Some patients consulted instead of buying over-the-counter (OTC) medication.

> *'I just happen to come up that day and I didn't fancy buying any because I'm on Income Support now.'* (16)

Theme 2: Factors influencing the perception of vulnerability

This theme was placed outside the division self care/consult, because references were used to either invoke or deny personal vulnerability to serious disease.

Category 1. Family history. Family history was mentioned in the context of the three serious conditions, peptic ulcer, cancer, and heart disease.

> *'Yes but looking back my mother suffered from a bit of gastric stomach — she always complained of it....'* (18)

> *'I know that I find my way of a touch of heart trouble. I think that's what done my father....'* (7)

The concept of personal vulnerability seemed to transcend blood relations, to cover spouses and even close friends, patients seeking a relationship between their experience and others known to them.

> *'I was frightened of cancer.... I lost a brother-in-law a couple of years ago but not in mine or my husband's family.'* (5)

Category 2: Past medical history. Many of the patients described previous experiences of investigation and diagnosis where the experience was 'distanced' by the use of 'they'.

> *'they didn't know what it was and they burst the gullet.'* (13)

Categories 3 and 4. Media and lay consultations. Only two patients mentioned being influenced by the media, and most said that they 'didn't believe things that they read'. Other patients conducted 'lay consultations' with friends and family before consulting the doctor.

> *'I go to a Leisure Centre most days and someone I've met there has had a hiatus hernia and he's been talking about this — how he didn't realize he had it.'* (30)

Category 5: Life expectations. Some patients also made reference to their expectations of life, often mentioned in the context of ageing processes, as being responsible for the symptoms.

> *'I spent five years in the airforce flying during the war and I never thought I'd live beyond the age of 60....'* (23)

Theme 3: Self-care

Category 1: Cancer suspected but continuing with self-care. A group of patients clearly suspected that their symptoms might have been caused by something serious but, paradoxically, this did not prompt them to consult. Some had considered cancer, but excluded it on the grounds of it not fitting the expected symptoms.

> *'Well, it could be a tumour but it certainly isn't bad enough for that. Or there might be blood when you went to the loo if it was a tumour which there isn't.'* (26)

Other patients expressed a fatalistic attitude to their symptoms:

> *'You don't like going down the doctor's otherwise perhaps you might hear something you don't want to hear.'* (25)

'I've said to everybody I'd rather die tomorrow quickly than live three years to suffer.' (8)

More frequent were expressions of dislike of possible treatment or investigation.

'I don't know what I thought it was, but I didn't like it and I don't think I ever discussed it with Dr...., I think I thought it was cancer and I was too frightened to mention anything....' (8)

'I don't like the idea of somebody messing me around.' (19)

'I'm not a coward but I don't want to have to go months with it.' (10)

Category 2: Simple indigestion

The commonest theme by far, being mentioned by more than half of the patients, was symptoms caused by food such as curry or cucumbers.

'I like kippers in the morning and about an hour afterwards they just repeat on me.' (16)

Other patients put their symptoms down to not chewing properly. The symptoms were usually described as mild and treated with lifestyle modification and indigestion remedies. Stress or a 'busy lifestyle' was mentioned by many as both an aggravating and an explanatory factor.

'I don't think I was chewing and digesting my food properly so I've taken myself in hand and now I eat more slowly and chew things a lot better.' (11)

Some had mechanistic ideas of 'valves', 'pressure', and the need to be rid of excess wind.

'A lot of wind (that) seems to rise and stick in my chest (and) the feeling of pressure.' (1)

'My hiatus valve is twisted or distorted in some way and it's letting air back in.' (1)

Category 3: Not wishing to bother the doctor

This was a common theme, often linked with the setting of time limits or strategies to consult if the symptoms got worse:

'I think when it comes on again I'll go down to the doctors, then when it goes I think it's all right then.' (25)

'The pain was so severe I would lie there and think if it went down my arms that was what I would do.' (19)

Category 4: Use of self-medication

Numerous proprietary preparations and home remedies were mentioned. Some patients seemed to be very regular takers of self-medication.

'It wasn't just the one bottle; I took dozens of them.' (10)

'I used to go every third weekend and stay and if I had any pain I would take my brother's tablets.' (8)

Construction of the explanatory model

The relationships between the themes and categories was examined to construct the explanatory model shown in Figure 2. A sequence of events occurred before consultation, reflecting a similar pattern to that found by Zola.[11] Cues, such as the death of a son (14), or symptoms that interfered with work or social life led patients to seek explanations for their symptoms. Trigger factors, especially sanctioning and the setting of time criteria, seemed to be particularly important in this process. The patients sought 'evidence' from their own previous experience or that of other family members and symptoms were related to causal and relieving factors and the patients' beliefs about the symptom patterns of potential causes. Finally, the costs and benefits of self-care or consultation were weighed up. In order to test this explanatory model, a final search of the data was made for refuting evidence; none was found.

Discussion

The role of achieving a shared understanding of the problem with the patient as central to the primary care consultation has been emphasized by Pendleton and Schofield[21] and the Royal College of General Practitioners.[22] It is apparent from this study of consultation behaviour that the perspective of the patient and of the doctor may differ widely. In the presence of dyspeptic symptoms, GPs will wish to diagnose gastric cancer at a curable stage, whereas many patients will have discounted cancer and will have other concerns, such as interference with lifestyle or sleep.

Support for the health belief model was found in references to personal or family vulnerability to serious illness and the perceived threat of the symptoms. Patients seek explanations in dietary habits or in the experiences of their family of friends. This is in agreement with Tuckett's[23] study of the consultation. Viewed in terms of theories of illness causation, these patients displayed a predominantly 'personalistic' view. The principal explanations for symptoms lay in the areas of degeneration (age), imbalance (of foods etc.), and mechanical interpretations of bodily function. This may reflect patients' expectations of increasing age and may not be generalizable to a younger group, although one might expect similar views on alcohol or spicy food.

Some patients were happy with self-diagnosis; yet others needed reassurance and explanation from consultation. The former type of patients, who avoid certain foods, make lifestyle adaptations, and self-medicate, are said in sociological terms to have an 'internal locus of control', whereas the latter are said to have an 'external locus' (these terms reflect a subject's belief in either personal or external factors as the major forces of change).[24] In contrast to previous studies, some patients (8 and 19) perceived medical interventions as costs, and others did not want 'to be messed around with'. As in Hackett *et al*'s[25] study of delay in seeking medical advice at the Massachusetts General Hospital, patients who worried more about cancer tended to delay seeking help more than non-worriers. The aim of consultation with dyspeptic patients in this age group must be to elicit their expectations and fears and negotiate a realistic appreciation of the potential risks and benefit of early diagnosis, but without raising unnecessary concern, as the risk of gastric cancer is still only 1 in 300.[3]

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