# General Practice Observed

## Temporarily Dependent Patient in General Practice

K. B. THOMAS

*British Medical Journal*, 1974, 1, 625-626


### Summary

**Of 3,848 consultations with patients at 330 general practice surgeries during one year, no diagnosis was made in 1,656, The latter received no effective treatment other than contact with their doctor, and were asked to return if they did not feel better. But 1,191 did not return, Subsequent inquiry showed that 976 (82%) said they had been made better, and a further 131 (11%) said that, though they were no better, they had not sought further treatment.**

**The "successfully untreated" patients were shown not to differ significantly from those patients in whom a definite diagnosis had been made, with regard to neuroticism, extraversion, intelligence, age, sex, marital status, social class, length of stay in the practice, number of consultations, and absence from work. These patients have been called "temporarily dependent" patients and their possible influence on diagnosis is discussed.**


### Introduction

Practitioners view psychological illness in many different ways.[1-9] An examination of 25 surveys in general practice showed that the reported incidence of psychiatric consultations varies from 3% to 65%, and that the rates are lowest (3%-12%) in surveys by doctors investigating general morbidity, and highest (24%-65%) in surveys by doctors assessing only psychological illness.[10]

General morbidity surveys have shown that there is also a variation in the incidence of many physical illnesses. Shepherd showed that in 14 practices there was a significant variation in the reported rate for nearly every category of illness, while in respiratory illness in female patients the variation exceeded that for psychiatric disorders.[3] A similar variation has been found in other surveys.[8 11-13] Thus the validity of much diagnosis in general practice seems to be in doubt.

This paper attempts to show two factors which are thought to make accurate diagnosis difficult. The first is the existence of those patients who do not seem to have evidence of illness, and the second is that many of them get better without any treatment other than contact with their doctor, and this encourages him to believe that his treatment has been effective and his original diagnosis correct.

**Waterlooville, Portsmouth**
K. B. THOMAS, M.D., General Practitioner

### Patients and Methods

The investigation was made by one partner in a group practice of four, covering 10,300 patients, in a suburban area of Hampshire (tables I-II). The patients were divided into the following groups: firstly, "service" patients—those who came for services; they were not ill, and came for inoculations, cervical smears, the pill; secondly, the "diagnosed" group—patients who presented with definite signs and symptoms of physical or psychological illness, and for whom a diagnosis was made, and thirdly, the "undiagnosed" group—patients who presented with little or no signs of physical or psychological illness, and for whom no definite diagnosis could be made. This investigation is concerned with the last group.

TABLE I—*Social Class of Waterlooville Electoral Ward compared with a Sample of 500 Patients who attended the Surgery during the Investigation*

| Social Class | Waterlooville Electoral Ward* | Surgery |
|---|---|---|
| | % | % |
| I | 300 (7·7) | 10 (2·0) |
| II | 690 (17·7) | 85 (17·0) |
| III | 1,500 (38·8) | 275 (55·0) |
| IV | 470 (12·1) | 78 (15·6) |
| V | 190 (4·9) | 6 (1·2) |
| Not classified | 710 (18·3) | 46 (9·6) |

*1966 Census.

TABLE II—*Age of 1000 of the Practice Population, compared with the Waterlooville Electoral Ward (Census 1966) in Parentheses*

| Age: | 0-14 | 15-44 | 45-64 | 65+ |
|---|---|---|---|---|
| 500 Females .. .. | 137 (168) | 223 (199) | 95 (66) | 45 (54) |
| 500 Males .. .. | 170 (152) | 210 (192) | 74 (92) | 46 (65) |
| Total | 307 (320) | 433 (391) | 169 (158) | 91 (119) |

Though the "undiagnosed" patients were seen during ordinary surgeries in a busy general practice, each consultation was standardized as far as possible and consisted of: history taking, when the patient was given time to describe his complaint; a physical examination; reassurance that there was no serious illness and that the patient would soon be well; and a request to return in one week if the patient did not feel better. These patients received no effective physical treatment. A few received nothing at all, and most received a placebo.

The record cards of all the untreated patients were examined and, if the patient had not returned during the month after the consultation, he was assumed to have got better ("successfully untreated" patient). If he had been seen by a doctor for any reason, either with the original complaint or with a different one, he was considered to have failed to get better ("failed" patient). The assumption that the "successfully untreated" patients had got better was tested by making two

separate surveys, three months and two years after the consultation. Patients in a 10% sample were asked by post whether or not they had got better and whether they had sought any further treatment.

The "successfully untreated" patients were investigated by comparing them with those patients for whom a definite diagnosis had been made (the "diagnosed" group). The Eysenck Personality Inventory Form B and the Mill Hill Vocabulary Scale Form I were used to estimate the level of neuroticism introversion, extraversion, and intelligence of a sample of 500 patients from the combined groups. The two groups were also compared for age, sex, civil state, length of stay in the practice, number of consultations, and absence from work during the four years previous to the investigation.

## Results

During the course of the investigation 5,409 consultations were made; 1,561 not for illness, but for services, leaving 3,848 consultations for supposed illness. Of these consultations, a definite diagnosis was made in 2,192 (56·9%) (the "diagnosed" group), and no diagnosis was made in the remaining 1,656 (43%) (the "undiagnosed" group).

Of the patients in the "undiagnosed" group 1,191 (71·9%) had not returned to their doctor. The remainder, who had returned to their doctor within one month, were considered to have "failed' 'in various degrees (table III).

TABLE III—*Results of Non-treatment*

| | Numbers | Undiagnosed Group % | Consultations for treatment % | Total Consultations % |
|---|---|---|---|---|
| Patients who did not return .. | 1,191 | 71·9 | 30·9 | 22 |
| Patients who returned with the same complaint .. .. | 228 | 13·8 | 5·9 | 4·2 |
| Patients who returned with a different complaint.. .. | 163 | 9·8 | 4·2 | 3·01 |
| Patients who were untreated twice .. .. .. | 64 | 3·8 | 1·6 | 1·1 |
| Patients who returned for certificates .. .. .. | 10 | 0·6 | 0·25 | 0·18 |

The sample of the untreated patients who did not return to the doctor were asked: "Did you get better?" and "Did you have any further treatment?" The results of both surveys are similar: 976 (82%) said they were better, and 131 (11%) said they had not sought further treatment even though they had not got better. This suggests that their concern for their symptoms may not have been very great, and indeed might have been further eased by the visit to the doctor.

No significant difference was found between the "successfully untreated" patients, and those for whom a definite diagnosis had been made (the "diagnosed" group), in regard to all the factors assessed such as neuroticism, introversion, intelligence, etc.

## Discussion

Most of this group of patients who received no treatment other than contact with their doctor improved. Moreover, they were asked to return to their doctor if they were no better, yet over 1,000 did not. Most of them are still in the practice and, when asked, maintain that they got better and that they had no further treatment.

This investigation has shown that about two out of five patients coming for treatment show no objective evidence of physical or psychological illness. This is not a new finding,[14 15] and for instance the College of General Practitioners Research Committee, in a survey conducted in 11 practices, found that the average for "firm diagnosis" was 55·5% with a range of 25·6%-72·4%.[13] Nevertheless, many general morbidity surveys in general practice show that a firm diagnosis is made for most patients.[16]

My "successfully untreated" patients did not differ from patients attending the sugery with definite illness ("diagnosed group"). They were not a homogenous group with special characteristics, nor was there any objective evidence to show that they were suffering from any physical or psychological illness: they were just patients who, in their response—reasonable or unreasonable—to the ordinary ups-and-downs of life, had gone through a phase of temporary dependence, and could therefore be called "temporarily dependent patients.

Hence in much of medicine in general practice the doctor cannot make an accurate diagnosis, and patients are often made to feel better with no treatment other than contact with him. This is simple, but any attempt at a diagnosis in these patients is not a process of logical deduction from definite evidence, but rather his personal interpretation of an ill-defined and unstable situation.[17] So these patients may be viewed as suffering from organic disease, psychological illness, social stress, or more recently, from behavioural problems. But there is no need for this complexity; these patients are not ill in the accepted sense of the word, they are temporarily dependent and want only reassurance and support from their doctor.

I would like to thank Mr. J. R. Compton, Professor I. A. Forbes, and Dr. Ian Skottowe for their advice in writing this paper, and Dr. Stephen Mackeith for his encouragement and interest. I am grateful to Mr. D. J. Mulhall who was responsible for the statistical work and the computer programme.

## References

1 Dohrenwend, B. P., and Crandell, D. L., *American Journal of Psychiatry*, 1969-1970, **126**, 1611.
2 Marinker, M., *Journal of the Royal College of General Practitioners*, 1967, **XIV**, 59.
3 Shepherd, M., Cooper, B., Brown, A. C., and Kalton, G. G. W., *Psychiatric Illness in General Practice*, London, Oxford University Press, 1966.
4 Cooper, B., *Journal of Psychosomatic Research*, 1964, **8**, 9.
5 Kessel, N., and Shepherd, M., *Journal of Mental Science*, 1962, **108**, 159.
6 Lin, T., and Standley, C. C., *The Scope of Epidemiology in Psychiatry*, Geneva, World Health Organization, 1962.
7 Ryle, A., *Journal of the College of General Practitioners*, 1960, **3**, 313.
8 Howard, C. R. G., *Journal of the College of General Practitioners*, 1959, **2**, 119.
9 Taylor, Lord, and Chave, S., *Mental Health and Environment*, London, Longmans, 1964.
10 Thomas, K. B., M.D. Thesis, University of Liverpool, 1972.
11 Ward, T., Knowelden, J., and Sharrard, W. J. W., *Journal of the Royal College of General Practitioners*, 1968, **15**, 128.
12 Lees, D. S., and Cooper, M. H., *Journal of the College of General Practitioners*, 1963, **6**, 408.
13 Research Committee, *Journal of the College of General Practitioners*, 1958, **1**, 107.
14 Crombie, D. L., *Journal of the College of General Practitioners*, 1963, **6**, 579.
15 Eimerl, T. S., M.D. Thesis, University of Liverpool, 1962.
16 Williams, W. O., *Reports from General Practice XII*, London, Royal College of General Practitioners, 1970.
17 Shepherd, M., Cooper, B., Brown, A. C., and Kalton, G. W., *British Medical Journal*, 1964, **2**, 1359.