

# Before the consultation: why people do (or do not) go to the doctor

In 1973, Irving Zola published a classic paper on a problem that he suggested:

*'... we think we know a great deal about but that, in reality, we know so little — how and why an individual seeks professional medical aid.'*<sup>1</sup>

Zola thought researchers made at least three assumptions about how and why a patient might appear in the consultation room and, in his view, none of them were justified. First, researchers assumed that patients are straightforwardly asymptomatic for most periods of their lives; second that, when patients do appear in the surgery, it is the seriousness and frequency of symptoms that prompt the visit to the doctor; and third that, when faced with such symptoms, patients who do not seek help are irrational. By contrast, Zola posited that most people have symptoms of something most of the time; that the frequency and/or seriousness of symptoms are not good predictors of attendance at the doctor; and that most people make decisions to seek (or delay seeking) help that are rational, at least if framed in terms of their own beliefs and values.

In the last 30 years, considerable attention has been paid to these issues and, in particular, to interrogating the assumptions that Zola identified. This issue of the Journal contains two contributions to this literature, the first concerned with how women manage urinary tract infection<sup>2</sup> and the reasons that prompt their attendance at a GP, and the second with patients' views about appropriate and inappropriate use of NHS resources.<sup>3</sup> In light of the findings in these papers, and supported by a brief review of recent parallel literature, Zola's conjectures continue to make sense.

Much of the current literature concerning decisions patients make before deciding to see the doctor concentrates on symptoms and conditions that, in normal circumstances,

would not be life-threatening in the short term. Nevertheless, drawing on Zola's first conjecture, the symptoms associated with these conditions are indeed noticed by patients.

A study that took place in the US in 2004 concerning type 2 diabetes found that patients could identify symptoms, but often attributed the symptoms to other causes and were not aware of their significance in relation to diabetes.<sup>4</sup> Such findings are not unique to Western settings. A study published this year concerning women in Iran with sexual dysfunction showed that most women had experienced at least one problem relating to sexual dysfunction and the majority of these women had sought no professional help due to 'time constraints' or denial that a problem existed.<sup>5</sup> These situations may highlight missed opportunities for diagnosis and improving quality of life, as well as the need to target health literacy and promotion programmes for these groups. Equally, they may indicate that some patients do not actually need to see a doctor.

If, as Zola suggested, many people do have symptoms of something much of the time, his view — that the decision to go to the doctor is only partly about frequency or seriousness of symptoms — seems to be supported by recent literature. For example, a study from Sweden in 2003 found that women who sought help for urinary incontinence were more likely to perceive their symptoms as socially unacceptable, rather than straightforwardly 'serious' or 'frequent'.<sup>6</sup> Men's help-seeking practices and health service use similarly are complex issues involving biological, psychological, and sociological considerations.

An Australian study in 2008 showed that men monitored their health status and made conscious decisions about when and how to seek help. Four factors were found to influence the ways men monitored their health: the length of time available to monitor health and legitimate

help seeking; men's previous illness experiences; the impact on their ability to maintain regular activities in the context of their daily lives; and a judgment of illness severity.<sup>7</sup> Another Australian paper reinforces these notions in the case of depression among men. Lower overall rates of depression in men compared with women reflect a number of issues, including psychosocial barriers to seeking help. Men are more likely to do something about their negative affect, such as self-medicating through alcohol or drugs, whereas women have greater emotional literacy so that they are more likely to volunteer how they feel to a health professional.<sup>8</sup>

A final factor that may influence help seeking for chronic conditions is comorbidity. A study from the US in 2005 found discussing one's probable insomnia with a physician was independently associated with having a greater number of medical conditions, being more highly educated, sleeping less per night, and greater perceived daytime impairment due to insomnia. This study highlights the question of whether identifying and treating one component of health status can have an impact positively on other areas, and whether the additive effect of a number of conditions may influence help seeking.<sup>9</sup> All of these studies come to essentially the same conclusion: the decision to seek help from a doctor turns on a complex mix of social, psychological, cultural and biomedical factors.

There is a nice twist to this conclusion in the paper by Adamson *et al* in this issue of the Journal.<sup>3</sup> In this paper a majority of people seem to think that their own use of the GP or accident and emergency service is driven by seriousness, but that other individuals use these services inappropriately. It seems that patients are able to rationalise their own help seeking, and self-perceived anxiety about a health situation (for whatever mixture of reasons) is associated with immediate care-seeking behaviour.<sup>3</sup>

The mixture of factors than underpin people's help-seeking behaviours also support Zola's third conjecture: that a decision to delay seeking help for acknowledged symptoms can make sense if it is interpreted in the light of a patient's own beliefs and values. In this issue of the Journal, Leydon *et al* discuss the process by which women come to a decision about help seeking. The women in this study followed a pattern of self-care first: they identified that they had a problem; then they attempted to address it. Only when the symptoms began to interfere significantly with everyday life did they finally make a visit to the doctor.<sup>2</sup>

These papers provide a number of lessons. First, for the most part, patients are not thoughtless users of health services; they do not lightly visit the doctor. They assess their own health status and they take measures to manage symptoms or cure disease. However, the logic that they follow in deciding to seek help may not necessarily resonate with clinicians, since it will be shaped by a wider range of factors than the straightforwardly biomedical. Understanding how and why patients choose to seek help from a doctor, and using this understanding to adapt the services that are provided, can help us to provide better care for patients and make more appropriate use of resources in the healthcare system. Just as importantly, it leads to better understanding and empathy,<sup>10</sup> both of which contribute to being a good GP.<sup>11</sup>

#### Annette Braunack-Mayer,

Associate Professor in Ethics, Discipline of Public Health, The University of Adelaide, Adelaide, Australia.

#### Jodie C Avery,

PhD Student, Discipline of General Practice and Discipline of Public Health, The University of Adelaide, Adelaide, Australia.

#### Provenance

Commissioned; not peer reviewed.

#### REFERENCES

1. Zola IK. Pathways to the doctor — from person to patient. *Soc Sci Med* 1973; **7**: 677–689.
2. Leydon G, Turner S, Smith H, Little P, and on behalf of the UTIS team. The journey from self-care to GP care: a qualitative interview study of women presenting with symptoms of urinary tract infection. *Br J Gen Pract* 2009; **59**: 490–495.

3. Adamson J, Ben-Shlomo Y, Chaturvedi N, Donovan J. Exploring the impact of patient views on 'appropriate' use of services and help seeking: a mixed method study. *Br J Gen Pract* 2009; **59**: 496–502.
4. Koopman RJ, Mainous A G III, Jeffcoat AS. Moving from undiagnosed to diagnosed diabetes: the patient's perspective. *Fam Med* 2004; **36**: 727–732.
5. Vahdaninia M, Montazeri A, Goshtasebi A. Help-seeking behaviors for female sexual dysfunction: a cross sectional study from Iran. *BMC Womens Health* 2009; **9**: 3.
6. Hägglund D, Walker-Engstrom ML, Larsson G, Leppert J. Reasons why women with long-term urinary incontinence do not seek professional help: a cross-sectional population-based cohort study. *Int Urogynecol J Pelvic Floor Dysfunct* 2003; **14**: 296–304.
7. Smith JA, Braunack-Mayer A, Wittert G, Warin M. 'It's sort of like being a detective': understanding how Australian men self-monitor their health prior to seeking help. *BMC Health Serv Res* 2008; **8**: 56.
8. Wilhelm KA. Men and depression. *Aust Fam Physician* 2009; **38**: 102–105.
9. Aikens JE, Rouse ME. Help-seeking for insomnia among adult patients in primary care. *J Am Board Fam Pract* 2005; **18**: 257–261.
10. Matthys J, Elwyn G, Van Nuland M, *et al*. Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. *Br J Gen Pract* 2009; **59**: 29–36.
11. Rogers WA, Braunack-Mayer, AJ. *Practical ethics for general practice*. 2nd edn. Oxford: Oxford University Press, 2009.

DOI: 10.3399/bjgp09X453495

#### ADDRESS FOR CORRESPONDENCE

#### Annette Braunack-Mayer

Associate Professor in Ethics, Discipline of Public Health, Mail Drop DX 650 205 The University of Adelaide, Adelaide, SA 5005, Australia. Email: [annette.braunackmayer@adelaide.edu.au](mailto:annette.braunackmayer@adelaide.edu.au)