Tolerating uncertainty in family medicine

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SUMMARY. In family practice, early undifferentiated signs and symptoms dominate many consultations. A physician must learn to tolerate uncertainty in addition to managing well-defined pathological processes. A series of steps are presented on how to approach the uncertain. I hope these will stimulate further comment and help to develop a body of organized and testable knowledge on the skills of managing the uncertain problems in family practice.

Introduction

SPOONER (1975) spoke clearly of the inadequacy of training in the management of patients who present with uncertain problems. He thought that medical schools fail to provide undergraduates with the education, training, or a model for the management of the uncertain. Spooner's objective was to record the inadequacy of training in managing uncertainty.

My aim is to describe a method for family physicians on how to manage uncertainty. This must become a skill which can be as appropriately applied as a protocol for investigating a specific problem. Medical literature is replete with well-honed methods for managing the known but offers little to residents (trainees) seeking to learn how to manage the unknown. However, McWhinney (1972a and b) and Hodgkin (1973) have made major contributions and have greatly influenced me.

I believe my suggestions are valid: I am not suggesting that they are complete. I hope they will stimulate further comments and recommendations which will begin to build a body of organized and testable knowledge on the skill of managing unclear problems in family practice.

In working out a system for management I have often been tempted to use clinical examples, but I have carefully avoided doing this. If the ideas are truly a system of management, they should be applicable to most or all problems of the uncertain. Therefore, no examples of uncertain problems are cited. Instead, I recommend that readers think of any situation in their general practice in which they have encountered a problem which is not obviously due to a defined pathological cause. Failing this, doctors can think of their experience with such ubiquitous undifferentiated complaints as "headache", "belly ache", "it feels like a lump in here" or a "sinking feeling".

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Management

Patients seek help from their physician at different times in the process of their illness. In order to encourage greater accessibility, the family physician tends to see patients earlier than do many other doctors. The cardinal attributes of the process of the disease are often in an undifferentiated or unrevealed state at the time of the first encounter. Yet at all times the family physician has to be prepared to manage the situation for the benefit of the patient; that is, he has to take decisions based on relatively few firm facts.

It is helpful first to review the natural history of the process of illness. It is essential for the physician to identify what point in the following sequence of events the patient has reached when he presents with his problem. As the trained observer of either a disease or the patient's concern for a disease, the doctor must have an understanding of the developmental process of illness. The essential steps are:

1. The patient is not at risk for the disease.
2. The patient is not at risk but is concerned about being at risk.
3. Prompted by the severity of distress, or after consultation with others, the patient brings the concern to the doctor.
4. The patient may have developed a disease but if he has it is in a presymptomatic, pre-identifiable state.
5. The patient's disease may be presymptomatic but may be identified by physical examination or a laboratory or x-ray test.
6. The patient has evidence of established disease.
7. The presentation of the disease can predict an

outcome of progress to returning to health, persistence without problems, or to proceed to disability or death.

8. Even at death with a competent autopsy, as many as 15 per cent of disease processes will fail to be fully explained by the postmortem examination.

Faced with this long sequence of possibilities, the family physician must strike a balance. He must make a reasonable decision with which he and his patient can live. He can either seek to test for evidence of an unknown process or wait for the development of the next level of disease activity. In order to help the physician to reach the decision some guidelines will be given.

The patient's perception and the physician's evaluation

The first and by far the most important aspect of the decision-making process is to understand the patient's level of concern for the problem. The essential question to ask the patient is: "What do you think it might be?" From the answer to this, the physician can determine the patient's perspective of the disease process. The patient's perspective may be that of acceptance of the same level of uncertainty, on the other hand he may be willing to accept a change of his level of concern, or he may be holding a totally unreasonable expectation; often, though, he may be concerned about a completely unrelated problem. The patient's level of concern must affect the acceptance level of the physician. Secondly, the reaction of the physician will affect the effort he will expend in establishing his data base. Uncertain problems presented by the patient deserve a thorough evaluation of the history and observation on physical examination. The established or obvious disease deserves and needs the least evalutation. Seeking identification of a probable disease comes somewhere in between.

If, therefore, uncertain problems deserve the most thorough search, what are the most valuable aspects of this? Probably the most valuable aspect is an extensive review of the history. Precisely when was the onset, when did it not exist, what makes it worse or relieves the distress, how big is it, what part of the body is it affecting now? Following close on the history is the precision of the physical findings. Paradoxically, uncertain problems deserve the most precise measurements. Careful recording of the size, the borders, the depth, the consistency and other characteristics will give a basis for recognizing the minute changes in the picture which may provide early identification of a changing process.

Unfortunately, very few laboratory or x-ray findings are helpful except in their negative contribution to the problem at this stage. They usually help by evoking the response, "at least it is not__________." However, the sum of these efforts on the history, physical, and laboratory support may be the most powerful aid to early recognition, if they are carefully elicited and carefully recorded. They are the data base from which to recognize early change. They are useless if ill-defined and poorly recorded.

Clinical judgement

The next level of management requires trying to measure the unmeasurable. The yardstick is imprecise but is effective in the hands of the experienced family physician. It is necessary to reach a conclusion about the severity or probability of importance. At the imprecise level of a list of possible differential diagnoses in undifferentiated disease one must first seek the answer to the question: "In the list of possibilities, how long would it take for the patient to die from each?" While this seems a crass question it is the basis of allocating priorities for the physician's mode of seeking his answers. This has to be balanced against the probability of occurrence. For example, if the list includes some severe morbid possibility with a low probability of occurrence, the physician must be able to predict the next likely sign or symptom of the disease. Using this process, he will be alert to the next early sign of a change toward a serious consequence.

Involving the patient

The physician must then proceed to the most important aspect of handling the uncertain. That is, he must involve the patient with the uncertainty. He must convert any activity-passivity role relation to one of active participation of the patient in his care and responsibility. It is essential to share uncertainty with the patient. While the admission of uncertainty seems to be difficult for many physicians, especially those in training, it is only personal pride rather than the patient's good which will suffer. To hide uncertainty often fails and when it fails the patient will rarely continue to co-operate. Patients also report that they expect the candid approach and criticize doctors for their frequent lack of it.

What then are the effective steps in developing valuable and useful involvement of the patient? The first suggestion is to allay any fear in the patient that he has been foolish to trouble the physician with his early concerns. Patient associations often report that patients are afraid that the doctor will chide them for unwarranted fears. At the same time, some of the medical profession are known to condemn patients for bringing their problems to the doctor at too late a stage. It therefore seems appropriate in most instances to congratulate the patient for his early reporting. This need not be an overt slap on the back; it is only necessary to convey the idea that the patient has demonstrated good judgement.

The next step is to build on to this identified good judgement by explaining the effects of misdirected treatment. Acceptance of this can be enhanced when the patient believes that his judgement is correct and not impugned.

An explanation of the inadvisability of treatment by

guess should cover such aspects as:

1. The development of resistance to inadequate treatment.

2. Hiding early signs of further development of a disease.

3. The hazards of the treatment.

4. The uselessness of costly treatment of the wrongly diagnosed disease.

In the management of uncertainty there are two important exceptions to the rule of requiring proof before treatment. First, in the case of preventive therapy of known contacts of infectious diseases or secondly, where it may be advisable to treat probable developing diseases for justifiable epidemiological reasons.

If the physician has been successful up to this point he will have helped the patient to become an ally, a partner in the care of the problem. The patient has become a mutual participant in the management of the uncertain and will usually be ready to accept a role of responsibility.

What responsibilities should be offered to the patient? The first should be the role of a collector of additional information. The patient should be encouraged to be a careful recorder of subjective symptoms. The patient should be asked to report changes of symptoms and to be more *precise* as to the circumstance of occurrence. The doctor or the patient may check with relatives for more extensive history. The patient should report observations noted by others of the changes which may occur. However, it is advisable to set a time limit to the observations which need to be reported, otherwise the patient may persist with observations and reporting for the next ten years about a transient disease.

The physician should request that the patient provides reasonable and related recordings of measurements. The most frequent observation requested is a recorded temperature with a thermometer. In addition, the measurement of a swelling by a measuring tape, recording of the number of ounces of fluids consumed, pulse rate at rest, the number of steps climbed or the distance walked, or a written record of menstruation may be pertinent and valuable measurements.

Because some patients may enjoy the role of the scientific observer, the physician may need to build in a double-blind control measure. To do this, one may add an unimportant observation for the over compulsive patient to use as a non-dependent variable. Hence the recording of stool colour in suspected kidney disease or the resting pulse in osteoarthrosis may help in assessing the value of the data collected by the patient.

It would be appropriate at this time to ask a simple question about the procedure described here: "Does this approach increase hypochondriacal behaviour?" The answer depends equally on the appropriate selection of the patient and the clear setting of parameters of observations by the physician. Obviously it is inappropriate to recommend this procedure to some patients and will be inappropriately used by others. A judgement on the probability of outcome must be made by the physician.

Emphasizing the physician's interest

Assuring the patient of the physician's interest in his problem is wise. This can be done by making specific plans for the patient's reporting. Without a specific plan the patient will readily realize that collecting his data with no plan for reporting it could be a trick. Therefore one must provide an opportunity for reporting. Although this is usually done through a follow-up consultation, it could sometimes take the form of a telephone report, a written note, or a report to the practice nurse. Arranging for the patient to report his observations is essential to an appropriate relationship.

The physician might consider the alternatives of probable diseases and wish to search for a diagnosis by a therapeutic trial; particularly at the level of uncertain disease it is stimulating to the physician to capitalize on his therapeutic armamentarium and use this diagnostic aid. However, the assumption that improvement of a condition by specific management is due to that management may be fallacious logic. The potential fallacy of logic is parallel to those discussed later under the caveats on re-evaluation. This is not to suggest that a well designed therapeutic trial is never appropriate. It is frequently a valuable approach, but it must be carefully managed and even more carefully evaluated.

Any relationship which is viewed as appropriate by the patient may have a therapeutic value in and of itself. Also, a positive suggestion may be accepted if it is not in conflict with the patient's feelings. It is therefore worthwhile to close the session with a positive suggestion for improvement of symptoms. This reaching for co-operation of the subconscious will not affect the recognition of progress of an organic disease but it will affect the outcome of the concern for the symptoms. I should re-emphasize that only a positive suggestion should be used. The subconscious poorly perceives a negative suggestion. Therefore, the statement: "I believe you will have no pain", is likely to be heard as, "I believe you will have . . . pain." The use of the permissive "believe" rather than the dogmatic, "you will" has the advantage of insulation from censure by the patient if the desired outcome is not forthcoming.

Objective re-evaluation

The last and vitally important aspect of managing uncertainty is an objective re-evaluation of the outcome. Only with an honest self-assessment can the physician know if he has become skilled in the management of uncertainty. Probably the easiest outcome to evaluate is when the process progresses to a classic identifiable disease. However, most problems get

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better without the physician knowing either what was wrong or why the patient got better. It can become hazardous to interpret this as the result of successful management because the management method may become an inappropriate habit. What might have happened? The patient may have got better as a result of the supportive therapies which were recommended because the problem improved on these therapies. Perhaps the patient got better because of something he did in addition to the recommendations. The process may have been self-limiting and would have remitted anyway without the management concepts. Or most hazardous, what was suggested was the wrong thing to do but the patient got better in spite of it.

A final caveat supporting the need for an honest objective evaluation of success needs to be made. Several diseases characteristically wax and wane. It is dangerous for a physician to be too satisfied that a problem has subsided because of his guidance when it has actually been a waning of the disease. At this point he may be observing the patient in a quiescent stage of a process when he should be involving the patient in a responsibility to report resurgence of recurrence. If a physician has a hunch about this possibility, a recommendation to the patient for a need to report the earliest evidence of recurrence may be a great support for early diagnosis.

Conclusion

The essential steps suggested in tolerating uncertainty among problems which patients bring to family physicians are:

1. The physician must establish his own level of tolerance for the uncertain.
2. He must understand the patient's level of concern for the problem.
3. A thorough data base of history and findings at the time of presentation should be recorded.
4. An assessment should be made of a concept of severity and a time-related plan established.
5. The physician should involve the patient with the uncertainty and convert the patient to an active participant in his care.
6. Arrangements for follow-up reporting by the patient should be made.
7. Positive recommendations for improvement should be provided.
8. The physician should perform an objective re-evaluation.

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