THE MEANING OF SYMPTOMS

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SUMMARY

By the time symptoms are presented to the doctor, a number of biopsychosocial processes would have occurred. Contrary to the popular belief that only the patient has jurisdiction over his symptoms; the doctor is also known to influence the eventual formation and expression of symptoms. The doctor too is not spared the processes of symptom attribution. An inter-personal approach is therefore necessary to fully understand the meaning of symptoms. And only when we respect the meaning behind the symptoms, and its subjectivity will we be able to fully appreciate and respond to the patient's suffering and woes.

Key words

Symptom, doctor-patient relationship, interpersonal model, family practice

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How does the patient get medical attention for his "dis-ease"?

Generally speaking, what bring the patient to see the family physician are symptoms. Similarly at the consultation, it is a well-transmitted custom for the physician to commence with an inquiry of the symptoms. Thereafter the physician attempts to decipher the complaints into medically meaningful entities, supported by his physical findings and investigations. Rational treatment then follows. This schema works best when the symptoms are directly manifested by the physiological processes in diseases. Indeed, many symptoms appear to be regularly produced by certain pathologic phenomenon such that they are almost implied indicators of biological disease. But the reality remains that symptoms are very much forefront subjective description of the patient's experience of illness. To acknowledge their subjectivity is to recognize the patient's meaning of disease and his personal suffering; to deny it may not only lead to failure of the physician to empathise with the patient, but also mislead the physician in diagnosis and treatment.

A case in point was published recently in the Singapore Medical Journal[1]. The theme of the case is likely to be familiar to family physicians: A 48-year-old teacher complained of fever to her regular doctor at the height of the Severe Acute Respiratory Syndrome (SARS) outbreak. The complaint of 'fever' persisted and remained unexplained despite extensive investigations and treatment for the next 2 months. She visited another doctor who demonstrated the absence of fever by temperature charting. She eventually revealed her depression because of her marital problems. Her 'febrile' symptoms disappeared soon after, and her condition improved with anti-depressants.

One may ask how could a teacher not 'know better' about whether she had fever or not? How did the symptom of fever come about? Why had she revealed the more vital part of her history only after 2 months and to the second doctor? Did the history change because of the second doctor's awareness to mental health issues, or was it his demeanour or even looks? Or was the diagnosis merely derived from the wisdom of hindsight?

The answers may be found in 2 related concepts as follows.

Concept #1 - Symptom attribution and presentation

Four processes are involved by the time the symptom is brought to the doctor's attention. Firstly, the patient becomes aware of an uncomfortable sensation, which may be created neurophysiologically. Secondly, the patient interprets the sensation according to its severity as well as the patient's own past experience, his knowledge, attitudes and practices. Thirdly, based on the interpretation, the patient decides whether the problem warrants a medical consultation. And finally, at the time of the consultation, interaction with the doctor can result in either expression or suppression of the symptom[2].

This patient possibly started with an awareness of body warmth. This may have emanated from an increased attention to body temperature at the time of the SARS outbreak (which is in tune with the 'national strategy' to screen for SARS by regular body temperature monitoring). It was duly interpreted as fever, which was also not 'unreasonable' in the context of the ongoing climate of concern about fever during the SARS outbreak. With this attribution, seeing the doctor was not a difficult decision. In fact, it was the social expectation and responsibility to see the doctor in such circumstances at that time. This social legitimization also meant that the doctor was more likely support the expression of the symptom. This last step will be further explained when the second concept is discussed. But even now, it becomes clear that a number of factors instigated the final presentation of 'fever' to the doctor, some of which are not necessarily intrinsic to the patient.

The processes of awareness, interpretation, decision, and expression/suppression are likely to apply in all kinds of cases, psychological or organic. Oftentimes, the processes are carried out subconsciously, although some commonly encountered verbal responses in daily practice hint to their existence: "I knew something was wrong as I have never had such a severe pain", "It did not start out that bad so I waited till now to see

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you", "I can't miss work so I am seeing you on my off-day", "I don't want to go to a hospital because that was how my sisters died", "I didn't think it was alright to see you for such a minor complaint".

The time frame for such processes also varies from seconds to months or years. The processes can explain why some patients rush to the emergency department for a relatively mild condition, e.g. muscular chest pain in a patient whose close relatives died of myocardial infarction may consider this symptom a matter of emergency. By the same processes, some patient will delay or never see a doctor because the symptoms are not attributed to a medical condition. An example not uncommon in our local context is the schizophrenic patient who will not seek medical attention because he attributes his symptoms to spirit possession. Similarly, societal stigma may prevent one from presenting with symptoms that directly relate to family violence, sexual abuse, or depression.

Concept #2 - Interpersonal relationship

How do doctors suppress/express symptoms? In practice, this may occur by direct questioning for 'relevant' symptoms, ignoring patients when they talk about symptoms deemed 'irrelevant', rationalizing away 'unimportant' symptoms, changing the subject or even telling them off when they 'stray'. Body language like frowns, smiles and yawns often betray the level of interest. And over a number of visits, the patients do get some inkling of which symptoms are 'permissible' and which are not.

But the process behind the doctor's selective attention at consultation requires some explanation. In the traditional disease model, the cause of the patient's illness is due to disease, and curing the disease will lead to recovery. The prototypical example of this model is infectious diseases, and it would appear that this was the model used in the initial consultations that our patient had with her family doctor. However, many patients' complaints do not fit well into disease syndromes, and like in this patient, the treatment of the 'obvious disease' does not necessarily lead to recovery from illness.

The next model is well known to students of family medicine; the so-called "patient as a person in his environment" model (figure 1). In this model, the patient's symptoms are manifested by the interaction of the disease and the 'person'. 'Person' refers to her cognition, intellect, attitudes, beliefs and behaviour, and well as her physical attributes. The same two-way interaction exists between the person and her environment. The 'environment' includes the many different realms of the person's external existence, such as physical, social, family, spiritual, cosmic realms. Using this model, we can appreciate how our patient's personal factors, such as depression, anxiety, fear of SARS, fear of separation, and so on could have influence the symptom formation and presentation. Likewise, extrinsic factors such as the prevailing national concerns with SARS, social expectations, family issues become evident.

This model would appear to be more holistic and can explain many of the phenomena in the case described. However, the obvious pitfall is that it assumes that the doctor can detachedly explore the patient's issues and derive all the necessary information to diagnose and treat her. This is far from the truth in the office consultation. The reality may be represented more accurately as an 'interpersonal' model (figure 2). In this model, the doctor and the patient are 2 separate entities, each with their own personal and environmental characteristics. The reason for their coming together is on the basis of a medical consultation. Even so, the interaction is limited within the confines of the so-called 'common ground', which is initially defined by the symptoms and their mutual expectations of the medical consultation. This common ground is dynamic and like in the previous model, is influenced by the 'persons' and their environment. What is in the common ground, including what symptoms are admissible, is determined by the interaction between the 2 persons and their individual environments – but when one person changes, so will the common ground, and so in turn the other person. From this, it becomes clear that since no two doctors are alike, it is therefore very possible that patients do present and behave somewhat differently when they encounter different doctors, just by reason of the different dynamics.

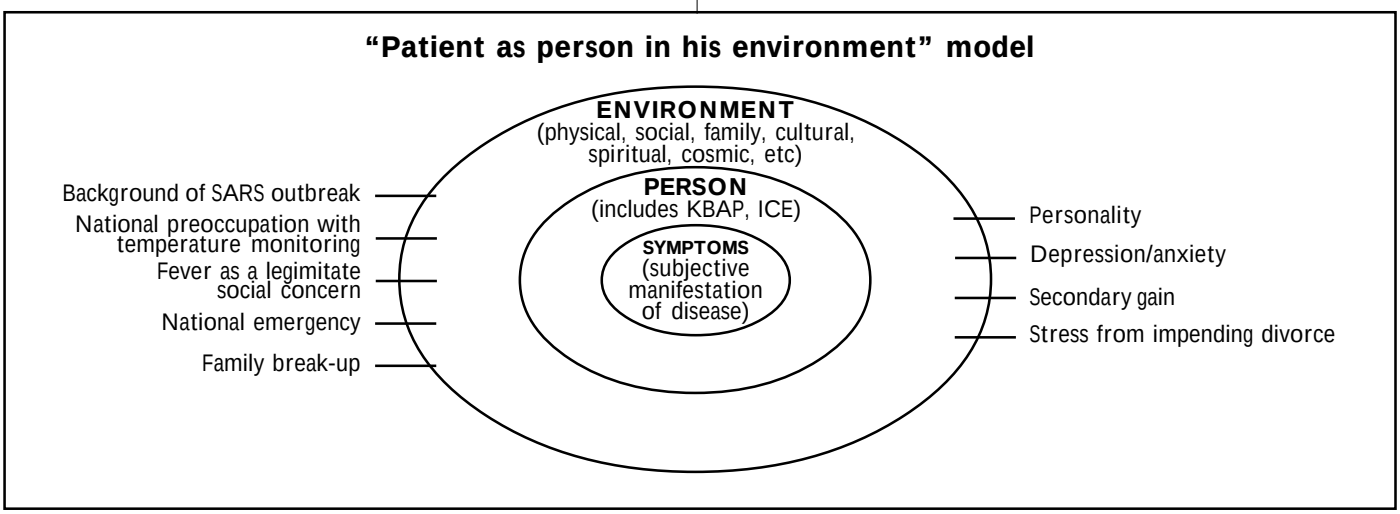

Figure 1: (KBAP – knowledge, beliefs, attitudes, practices, ICE – ideas, concerns, expectations)

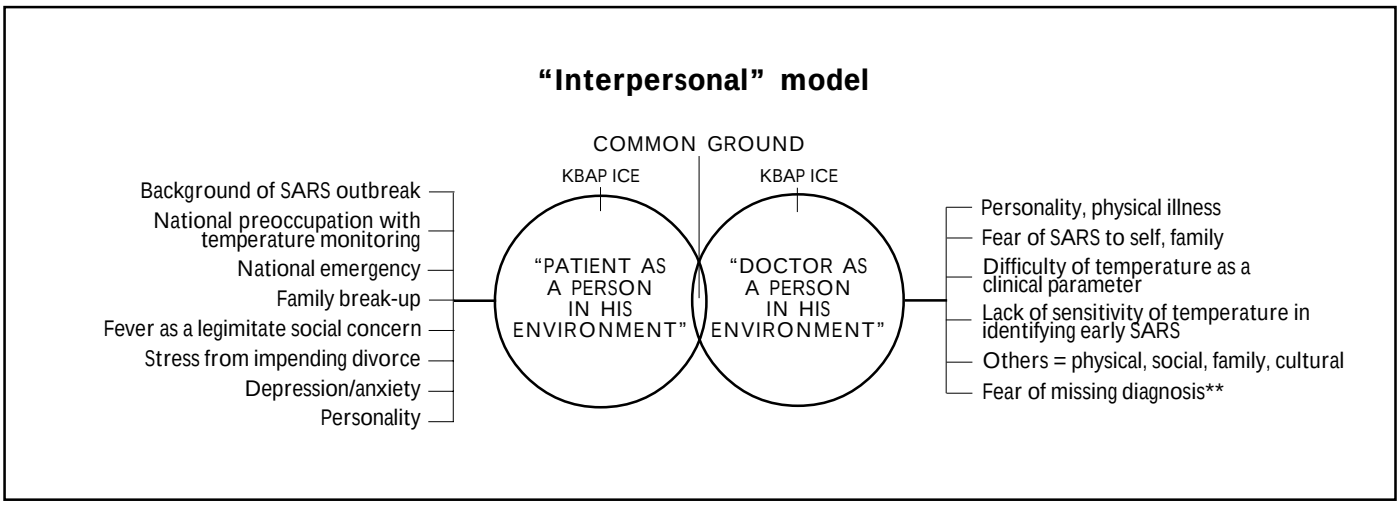

Figure 2: (KBAP) – knowledge, beliefs, attitudes, practices, ICE – ideas, concerns, expectations)

This model also implies that doctors are not spared the same processes of symptom attribution. Applying the model to our case, it is possible to postulate the circumstances the first doctor might be in and what factors might have contributed to the eventual common ground (figure 2). Somehow, the common ground in the interaction between and patient and her first doctor precluded the full expression of her depressive illness.

It is interesting that the patient continued with the initial doctor despite not deriving any clinical improvement. While this may certainly attests to the trust in her doctor, it may also be discernable from figure 3 that the interests of the patient and her initial doctor might have been somewhat complementary (a 'good' fit in the common ground like 'key to lock'). While there may be other circumstances where this might be beneficial, this case illustrated the possible danger of a colluding relationship between doctor and patient. One example of collusion might involve the patient seeking emotional relief from the assurance of receiving medical treatment, while the doctor assures himself that something is done by dispensing symptomatic treatment. Another possible scenario may involve the patient who derives transient relief from her uncomfortable feeling through the normal results from investigations, such that she will keep returning for more investigations and confirmations once the sense of relief expired. The doctor on the other hand may derive a positive experience from the satisfaction and relief of his patient and/or his own relief that the condition is not SARS, and so continues to engage in investigations. Both these scenarios may be understood in terms of subconscious conditional responses. The patient and the doctor may also modify their symptom attribution, frequently without their conscious knowledge, to conform to the colluding relationship that had brought about the symptomatic relief, albeit transiently.

From a psychological point of view, what might occur at a consultation may be represented diagrammatically as in figure 3. The interaction of the patient and the doctor therefore exists in both the conscious and unconscious planes, with interactions occurring vertically, horizontally and diagonally. The interactions at a consultation are thus multidirectional, influencing the doctor and the patient both consciously and unconsciously.

The 'interpersonal' model can also be applicable to other difficult practice scenarios such as "the difficult patient", or in "the non-compliant patient". In the former, one might consider difficulties in the patient, the doctor and their mutual interactions. In the latter, it may be construed as a case of poor fit in the 'common ground' (the patient is perfectly compliant, but only with his own goals and not with the doctor's).

CONCLUSION

Symptoms are the patient's subjective description of his "dis-ease". Disregarding the subjectivity may be deleterious in 2 ways: firstly, the symptoms no longer become informative, or even become misleading; and secondly, it denies the patient of the experience of his suffering, and therefore damages the doctor-patient relationship.

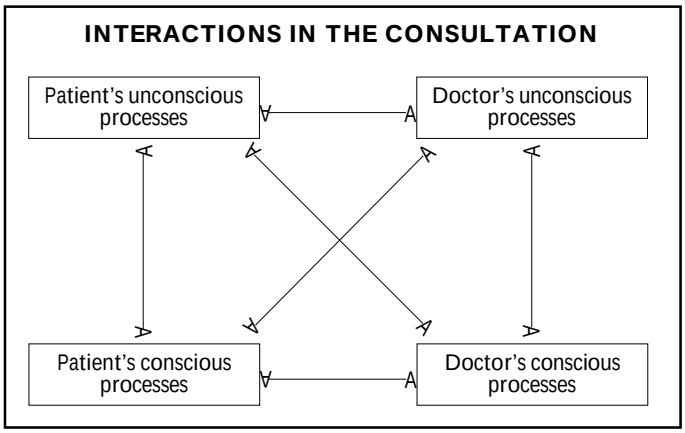

Figure 3

Particularly in mental health conditions, the meaning of symptoms to both patients and doctors, can significantly affect illness presentation. It is important to realize that the meanings of symptoms are derived from complex personal and environmental factors. Furthermore, there is an interpersonal interaction with the doctor, such that the final script of the symptomatic history cannot be ascribed solely to the patient alone[3]. Being aware of this relationship may be the best approach to respond fully and appropriately to the woes of our patients.

REFERENCES

1. Tan YS, Cheong PY. Fever attribution in the SARS outbreak. SMJ 2003 Vol 44(11): 590-4.
2. Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology. Ann Intern Med 2001; 134:917-25.
3. Elder A, Holmes J. The need for a new approach. In: Elder A, Holmes J (eds). Mental health in primary care. Oxford University Press 2002.