Family Practice Grand Rounds

The Patient's Hidden Agenda

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DR. ALEC STYLE *(Assistant Professor of Family and Community Medicine)*: The title of our presentation is "The Patient's Hidden Agenda." In order to prevent us from having a hidden agenda, I intend to begin by explaining our definition of the term "hidden agenda" and then outlining the educational objectives and structure of the rounds. It is hoped we will then have a common definition and we will all be discussing the same things.

We have defined the "hidden agenda" as "the covert conscious or unconscious motivation that a patient has for contacting a health provider or health care system." This meaning should become clearer as the presentation progresses. The rounds will begin with two case presentations. The first presentation will be by Dr. Michael Kelley who is a second year family practice resident, and the second will be by Ms. Eileen Rafferty who is a family nurse practitioner. All three of us work together in the same health center. Following these two presentations I will discuss them and provide a conceptual framework for looking at the "hidden agenda." We will have time at the end for questions because previous evaluations of Family Practice Grand Rounds have requested it.

We will have achieved our objectives at the end of these rounds if you are able to do the four following things. First, we hope you will be able to describe a classification of reasons why patients present to their physicians. Secondly, you will recognize the difference between the overt presenting problems and the covert hidden agendas that occur in some of your patient encounters. Thirdly, you will be able to list clues in your patient encounters that indicate that your patient's problems are not the overt presenting ones. Finally, you will be able to describe a number of techniques that can be used when you suspect a patient's problems are not the overt presenting ones. Our objectives are cognitive because in this setting we are unable to teach specific skills. If we raise awareness and increase knowledge we will have achieved our objectives.

We will now go on to the first case presentation by Dr. Michael Kelley.

DR. MICHAEL KELLEY *(Second year family practice resident)*: The patient I have to present is a 27-year-old woman named Diane, who was in an auto accident last April. She received only minor injuries but the other driver was quite seriously injured and is now a paraplegic. According to her, the police report places the fault with the other driver, citing him for speeding and running a stop sign. In addition, he was uninsured.

Diane was seen in the emergency room that night and discharged after observation but returned to the emergency room two days later with severe abdominal and back pains. She was admitted at that time and after a two-week hospitalization was discharged with a diagnosis of musculoskeletal pain secondary to the auto accident. She did well for a few weeks and was ready to go back to work, but in late May she had a sudden increase in her back symptoms and was readmitted for a myelogram, which proved to be negative. In retrospect, at about that time she began dealing with some of the legal issues involved with the accident. The other driver was suing her for a million dollars and she filed a countersuit to cover her medical expenses. After that second hospitalization in May, she had a great deal of difficulty with her back. She rarely went more than a week without some sort of contact with the

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health center regarding her back; her general pattern of usage was to call by telephone and usually speak with whomever was on call that night. She received a number of prescriptions for analgesics and muscle relaxants and was advised to rest in bed for back pain.

My first contact with her came about this time when I inherited her from one of the residents who was leaving the program. She called me and told me about her back pain and was wondering what to do. At that time we did talk about her legal suits that were pending and I told her that I wasn't sure the pain would get better until those legal issues were resolved. Acknowledgement of the fact did not change anything and we went through the whole summer with these frequent contacts that were neither satisfying nor productive. By the end of the summer both she and I were very frustrated with the lack of progress. However, something happened in September, when she had to file a deposition with the other driver's attorney about the accident. During the week she was working on that, her back pains increased tremendously and she was unable to do anything at all except stay in bed. I saw her at that time and was convinced she had a nerve root compression and arranged to see her with an orthopedic surgeon in the health center. He felt the examination was inconsistent and that there was no nerve root compression. With that reassurance I pointed out to her the obvious correspondence in time with her having to face those legal issues and the increase in her symptoms. She accepted this and we agreed on a six-week contract to work not on her back pain, but on the emotional issues that were increasing the disability from her pain.

During the first session we explored her past history more carefully, and this was very revealing to me. She had had quite a difficult childhood. Her mother was an alcoholic and she was in and out of foster homes until she was permanently placed with relatives at the age of seven. One of Diane's earliest memories was of her mother telling her, "When I'm dead I want you to see me in my coffin and know that you put me there." When Diane was 14 years old she was hospitalized in New York with a "nervous breakdown" and after that received counseling. What she remembers of the counseling was dealing with the guilt she felt toward her mother.

Getting back to the accident, she said that she knows intellectually that she was not responsible for the accident, but she still feels very guilty for the fact that the other driver has ended up a paraplegic. I suggested to her that her disability from the back pain could be one way of punishing herself for that guilt and we ended the session by my asking her to think about the way she approached her guilt when she was in counseling as a teenager.

She did not show up for any more of the contracted sessions. But since then her pattern of using the health center has changed quite dramatically. I have seen her a number of times, usually bringing in one of her children who was sick with an acute illness, such as an ear infection or pneumonia. However, the last two months she has begun coming in herself for acute, objectively definable illnesses. I last saw her two days ago and asked her about her back. She said that "I still have the back pain but now I can live with it."

DR. STYLE: Thank you. We will now go straight into the second presentation.

MS. EILEEN RAFFERTY *(Family nurse practitioner)*: I would like to present a family that I have known since the fall of 1978. My reason for presenting this particular family is to point out how their pattern of presentation was a clue to issues other than their organic complaints.

The immediate family is the mother and her three children, the oldest girl (8) from her first marriage, and her son (4) and daughter (3) from her second marriage.

The mother has significant findings in her past medical history. She had a series of chronic urinary tract infections and renal calculi in the early 1970s. According to the record, she had significant abdominal pain at the time. She has had a tubal ligation and pelvic inflammatory disease in the past. She was abused by her father as a child and also by her first husband.

The eight-year-old daughter is essentially well, being seen periodically for health maintenance and minor acute illness.

The son has recurrent otitis media and now has myringotomy tubes. He has a speech dysfunction, thought to be partly due to chronic serous otitis and is being followed by a speech pathologist.

The younger daughter has chronic subluxation of the head of the radius (nursemaid's elbow) and chronic rhinorrhea during the winter.

I felt this family was using the health center quite frequently. They had 45 visits in a 14-month

period, some of which I feel were not necessary. Seeing them through this period, I got the feeling that there were other issues bringing the mother to the health center.

The children were first seen for health maintenance in August 1978 by another provider. Later that month the mother began to have abdominal pain which persisted until I met her in October. Because of her history of renal problems, the resident following her had done a clinical work-up which was negative.

The mother admitted stresses at home which she did not want to discuss; it was then that I felt the pain was functional in nature. I met her when I was covering for the resident in October and she did not want to discuss her stresses.

At the end of the month the mother was once again seen by the resident; she admitted at that visit having been seen once by a psychiatrist. It was her perception that the psychiatrist had told her boss about her visits, causing embarrassment at work and eventually causing her to leave the job. She made it quite clear that she did not want counseling and, I feel, that she did not trust medical providers.

I did not see the family until January 1979, when the children began coming in for ear infections. At a follow-up visit for them I touched base with the mother and asked her how her abdominal pain was. That was not as much an issue as her inability to sleep while working nights. I asked her to return so we could discuss it.

She did, and throughout the visit I stepped very softly, asking about her relationship with the children, wanting to establish a trusting relationship with her. I gave her some practical tips on sleeping and she returned in two weeks.

This visit was the turning point. Once during the interview when we were discussing her doing "everything for the kids," I asked her if she was "doing anything for herself." It was as if I had opened Pandora's Box. She began sobbing and said how she resented being a single parent on welfare, she hated having to work nights, that she wanted more for her children than what she had had as a child. I had given her permission to share her fear and anger at a time when she was ready.

There were many visits with her and her children over the spring. These contacts were important for our relationship because a contact with the children was also a contact with her. Some were unnecessary though and finally in the spring I confronted her by saying, "You don't have to have an excuse to come and talk with me."

My goal was to get the mother into a counseling situation. Knowing her past experience I wanted to approach this carefully. Much to my pleasant surprise she readily agreed in the fall when I asked her to join the therapy group at the health center.

Since the mother joined the therapy group, the health center contacts—visits and telephone calls—have dropped considerably. I feel she is more confident and happy with herself.

In summary, I feel this family shows that the frequency and patterning of visits clustered around stressful times; the increase in use of the center clued me into other issues at home. This case is also a good example of people needing permission in a trustful relationship before they are able to open up. It is an excellent example of the beauty of family practice—a visit with the children is also a visit with the parent. Finally, as we stated in our introduction, persons often come with hidden agendas, in this case an unconscious hidden agenda.

DR. STYLE: My task now is to tie these two presentations together. One of the exciting aspects of family medicine is that it can be practiced on many different levels, according to our own individual interests. One level is the disease level. Physicians listen to the patient's presenting problems, ask questions, examine the patients, and order a number of investigations so that they can make a diagnosis of a specific disease. They treat the disease and the patient leaves and that is the end of it. On a more abstract level, physicians may make what I call a systems diagnosis. Each of us is a part of many systems. There is a physical body system, a mind-body system, a family system of the relationship between family members, and a community system of the relationship between individual, family, and community. Dysfunction in any of these systems may bring the patient to the physician and it is the role of the physician to focus on the dysfunctional area. I may sum this up by quoting the French "Il n'y a pas de maladies. Il n'y a que des malades," which means there are no such things as diseases, there are only sick people. Dr. Kelley and Ms. Rafferty have both shown us how they make a systems diagnosis.

One of the many non-wisdoms I learned in medi-

cal school is that patients visit their physicians because they have a problem, which they openly present because they want it eradicated. I have since learned that this is far from the truth. A few years ago McWhinney wrote an article in which he classified patient behavior, listing seven reasons why patients visit their physicians[1]:

The first is called *limits of tolerance* and is perhaps the most common reason. It certainly is one of the easiest to understand. For example, a patient will present when pain has reached an intensity that he can no longer tolerate.

The second he calls the *limits of anxiety*. The patient perceives a symptom, gives it a meaning which is very anxiety producing. When the anxiety reaches an intolerable level he goes to see his physician. We have all seen patients with what we regard as minor or trivial problems but which to them are serious: the patient who finds a mole and thinks it is cancer; the mother who finds an enlarged lymph node and thinks it is a lymphoma.

The third category is what McWhinney calls *signal behavior*, which is similar to our "hidden agenda." Signal behavior is when a patient has a significant problem which he/she does not state as the presenting one.

The fourth reason is *administrative*. A patient presents because he wants a letter for school or work or some other bureaucratic reason. Many physicians do not like this aspect of their work.

The fifth one is *opportunity* and we have seen examples of this in both of the above case presentations. A patient when seeing a physician will use the opportunity to ask about another problem. A common example illustrated above is a mother who brings a sick child to the office and then asks the physician about her own problem. The danger for the physician is that he may ignore the latter problem because of its apparent inappropriateness when, in fact, it may be of major significance.

The sixth one is *no illness* and is similar to health maintenance.

The seventh one is *lanthanic* which is a term McWhinney borrowed from Feinstein's book *Clinical Judgment*.[2] This is the situation when the physician finds disease of which the patient is unaware. An example of this is someone who comes into the office for a blood pressure check, which is found to be high, and is then asked to return at a later date for a repeat recording.

I would now like to concentrate on "signal behavior" or what we call the "hidden agenda." In the same paper McWhinney has described some of the cues to signal behavior. These may be seen in individuals and families. One of the important concepts in family medicine is treating all family members, thus enabling the physician to gather data about the individual members and the family system. By repeated contact over time with family members or all of the family, the physician may build up a large amount of data which it is hoped will be filed by both memory and a record keeping system.

McWhinney's cues may be looked at for the individual or for the family. His first is *attendance for minor illness*. Someone or a family member presents a trivial illness for no apparent reason. Ms. Rafferty gave many examples of this.

The second is *attendance for chronic illness without a change in severity*. A patient with essential hypertension who comes for a blood pressure check every three months, suddenly shows up out of schedule. Why? I find it useful to ask myself periodically, "Why has this family member come to see me at this particular time?"

The third one is *attendance for unorganized symptoms without organic pathology*. An important concept to primary care medicine, including family medicine, is that patients come to the physician or other provider with undifferentiated, unorganized symptoms. Unfortunately, in medicine we tend to organize these symptoms and problems along the lines we have been taught in medical school. If we are disease level oriented physicians we will tend to organize them in this way so that the patient's symptoms make sense to our own conceptual framework. One of the reasons for making system level diagnoses, which will include both the psychological and the social aspects of illness, is so we do not organize every presenting symptom along the biomedical disease pathway; once done this way it is very difficult to go back and undo it.

The fourth clue is *delayed recovery from an illness or injury*. The first presentation clearly illustrates this. The failure of the patient's backache to improve was unexplainable in physical terms.

In 1975 McWhinney and his colleagues published a second paper in which they looked at how frequently five different family physicians diagnosed "signal behavior" in 389 patient encounters.[3] They found that "signal behavior" was diagnosed

in 13.9 percent of encounters. An interesting finding was the variation between physicians in making this diagnosis. The range was from 5.7 to 34.1 percent; this illustrates another important concept, that the conceptual framework of the person providing the health care strongly influences the diagnosis. I am not making a value judgment by saying that the provider who recognizes "signal behavior" in 5.7 percent of cases is wrong compared with the one who recognizes such behavior in 34.1 percent of cases. This partially explains why there are huge variations in the frequency of psychosocial problems within family medicine.

There are many things that physicians and other providers need to learn in order to increase their ability to recognize patient's and family's hidden agendas. The first is to develop a wider conceptual framework of illness as already described. This means recognizing the many patterns of normal and abnormal individual and family behavior, some of which we have described.

A technique which we have borrowed from behavioral science is a patient- or family-centered style of interviewing. In the two case presentations, Dr. Kelley and Ms. Rafferty could easily have asked specific closed-ended questions about their patients' presenting symptoms. Instead, their style of interviewing uses open-ended questions and they give the patient time to explain what is happening. This makes it much easier to pick up clues about any hidden problems.

In contrast to interviewing, I was taught history taking in medical school. I was taught to listen to and be aware of patient's verbal behavior; this ignores the patient's nonverbal behavior which is a very important part of communication. I was also taught to ignore my own nonverbal behavior. The latter two give vital clues to covert issues and problems. I saw a woman in my office last week with abdominal pain. While she was telling me where the pain was, she clenched her fists in a very tight way. Why the sudden tension in her body? What does it mean? I also think it is important to be aware of ourselves, our body, our feelings. This means asking ourselves questions. Am I feeling angry toward this patient? Am I feeling agitated? Do I like her?

I will end with what I call the three As of effective communication for family physicians: *awareness* of what the patient is saying with words and body language; *acceptance* of what the patient is saying and not ignoring parts of the communication; and *availability* to the patient and family over a long period of time to gather data and develop a closer relationship. Also, do not forget that we, as providers, have our own "hidden agendas" that may be very important. The fact that we have not covered this today does not mean that we do not recognize its significance.

FACULTY PHYSICIAN: Ms. Rafferty, were you surprised that your patient cried when you asked her if she was doing something for herself?

MS. RAFFERTY: I had the feeling that she was going to cry but I was surprised by how fast and dramatically she did. After she started to cry I left her alone for about five minutes, by which time she felt much better. She then told me that she had not cried in two years and it really felt good.

FACULTY PHYSICIAN: I am concerned about the recurrent "nursemaid's elbow." Do you think the mother is a heavy discipliner and are you worried about child abuse?

MS. RAFFERTY: The orthopedic surgeon, who has been treating the child, explained that it is a common problem and can happen with minimal trauma, such as picking a child up by the arm in the grocery store. I perceived her to be a caring mother. Part of her problem is that she wants to do too much for the children and does not know when to take care of herself.

DR. STYLE: I know this mother well. Although discipline is an issue with her in that she is often ineffective, there have never been any signs of child abuse.

FAMILY PRACTICE RESIDENT: You have addressed identifying the "hidden agenda." What do you do when you perceive it in the course of a person's 15-minute scheduled visit; and you are already way behind, there are other people waiting for you, and you are now obliged to say, "Well let's talk about this next week." Is that the most appropriate approach? Are there any other kinds of techniques that we can employ?

DR. STYLE: This is an important question. Unfortunately, there are no hard and fast rules about the answer. I think that recognizing the problem and acknowledging its importance to the patient are two initial things to do. Usually I ask the patient to make another appointment so that we will have more time to discuss it. However, it has to be a clinical judgment whether you can do that or need to deal with the problem immediately.

FAMILY PRACTICE RESIDENT: What is meant by the "Oh, by the way, doctor," phenomenon?

DR. STYLE: This takes place when patients, who have their hands on the door as they are walking out of the examining room, drop a verbal bombshell in the form of a psychologically meaningful statement. This happened to one of our residents last week, when one of her patients said as she was leaving, "Oh, by the way, I think I am homosexual." This phenomenon is so common that we should all listen to what our patients say just before they leave.

FACULTY PHYSICIAN: In response to that earlier comment about what to do when you are faced with a "by the way" or something like that . . . I really disagree that you can make another appointment to deal with the problem. In a number of situations, the emotional tension which builds up and allows the patient to articulate what they have just said is not going to be reproduced next week. I think it is one of the things you really have to be flexible about and at least allow some catharsis at that time, so that you can maximize the benefit of that confession. In my experience if you do not do that the patient will probably not come back and you will probably not recapture that moment.

MS. RAFFERTY: I agree—it may be necessary sometimes to focus on the issues as they happen. I like to tell the patient that I understand how hard it was to raise this important issue. I discuss this and their concerns briefly and then ask the patient to return when I have more time. In my experience when I have done this the patient has come back.

DR. STYLE: Time has run out for any more questions. Thank you all for attending today.

References

1. McWhinney IR: Beyond diagnosis: An approach to the integration of behavioral science and clinical medicine. N Engl J Med 287:384, 1972

2. Feinstein AR: Clinical Judgment. Baltimore, Williams & Wilkins, 1967, p 145

3. Stewart MA, McWhinney IR, Buck CW: How illness presents: A study of patient behavior. J Fam Pract 2:411, 1975