

The Decision to See the Physician: A Clinical Investigation

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To study why people decide to see a physician, 150 consecutive patient-initiated visits to a university family medicine center were evaluated prospectively.

Physician and patient agreed about the reason for the decision to see a physician in 40 percent of encounters. Correlation was stronger for visits for health maintenance and weaker when patients were told to come, had psychosocial reasons, or experienced an event triggering their decision.

An empirically based taxonomy of eight reasons for the decision to see a physician is presented: symptom existence causing pain (eg, cystitis), symptom existence causing anxiety (eg, child with fever), symptom persistence causing pain (eg, pharyngitis), symptom persistence causing anxiety (eg, skin rash), health maintenance visit, psychosocial reason, told to come, trigger event.

Patients with psychosocial reasons presented ostensibly with symptom existence, symptom persistence, or health maintenance needs.

Patients who were told to come were either unwilling to seek care or unable to interpret their symptoms appropriately.

Two thirds of patients decided themselves to see a physician; one third consulted someone else; no one used books or the media to help decide.

Yudkin¹ observed more than 20 years ago that "for all patients coming to a doctor there are two groups of diagnoses. One group answers the question 'What is the matter with the patient?'; the other, 'Why is the patient consulting you now?'"

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Family physicians are trained in the biopsychosocial model of disease² and have started Balint seminars³ to learn about the second diagnosis. With some exceptions,⁴⁻⁸ however, family physicians have not pursued the "second" diagnosis systematically, nor have they scratched the surface of the study of illness behavior,⁹ a field of active inquiry among sociologists,¹⁰⁻²⁰ epidemiologists,²¹⁻²⁵ and psychiatrists.²⁶⁻³²

Illness behavior refers to "the ways in which given symptoms may be differentially perceived,

evaluated, and acted (or not acted) upon by different kinds of persons."⁹ How patients decide to see a physician is often a paradox.³³⁻³⁵ It is one aspect of illness behavior that challenges family medicine as a clinical science.³⁶

A project was undertaken to investigate why people decide to see a physician from the perspective of the family physician at the time of patient-initiated office visits to a university family medicine center. The objectives were (1) to develop and apply a method for family physicians to study the illness behavior of their patients, and (2) to provide an empiric description of the decision to see a physician, one aspect of illness behavior.

Methods

Data were collected at the Family Medicine Center of the Medical University of South Carolina. The individual responsible for the decision to see the physician (ie, the decision maker; usually the patient himself, but for pediatric patients, the responsible parent) was interviewed following a specially designed protocol. Only patient-initiated contacts were evaluated. Follow-up visits or appointments advised by medical personnel were excluded. The interviews were conducted by the physician in his or her examining room. Patients were asked to participate by answering several questions concerning their decision to see a physician. No one refused to participate. In all other respects the encounters were routine.

Two physicians were recruited to help collect data. The interview protocol was discussed, and the instructions for its use were explained. A videotape was presented of the author interviewing a patient according to protocol. Both recruited investigators practiced conducting patient interviews with the protocol before data collection began. These steps were taken to minimize observer bias as much as possible.

The interview protocol was taken initially from the format of Stewart et al.⁵ Redesigned to be unobtrusive, easy to administer, and comprehensive, it was field tested by the author in patient encounters at the emergency room of Charleston Memorial Hospital. The process of revision and retesting took place three times, and a total of 141 test encounters were performed in creating the final pro-

tol. Explicit instructions for conducting the interview according to protocol were also created.

The final protocol included 15 questions and space for additional comments. Questions 1 through 11 elicited demographic details, the patient's chief complaint and its duration, whether treatment had been sought elsewhere, from whom, and when the patient had decided to see the physician. Question 12 asked what made the person who came to see a physician decide to come for this problem; the response was recorded verbatim. Question 13 listed ten choices for the physician to record his impression of the reason for deciding to come. Question 14 asked whether the decision maker had obtained help from parents, family, friends, books, television, or elsewhere in deciding to see a physician. Any help sought in making this decision was defined as lay consultation.³⁷ Question 15 asked for the diagnosis.

Specific criteria for each of the physician's impressions in question 13 were established. For the choice "duration or intensity of pain or suffering," the decision maker was required to use the word *pain* or otherwise imply that physical or emotional distress prompted his decision. For the choice "duration or intensity of fear or worry," the decision maker was required to use the words *afraid*, *worried*, or similar expressions to communicate these emotions, and to respond affirmatively to the question "Did you decide to see the doctor primarily because you were afraid or worried about your symptoms?" For the choice a "new problem arose," the decision maker was required to cite a medical, social, or other problem that triggered the decision to see the physician. For "frank psychosocial problem," the decision maker was required to acknowledge that an actual psychological or social problem in his life led him to decide to see the physician. For "ticket behavior," the decision-maker was required to present with a somatic complaint that on further questioning revealed a behavioral problem which was discussed with apparent relief. For "signal behavior," the decision maker was required to present with a somatic complaint without apparent organic basis but with a large behavioral component that the patient did not recognize. For "schedule allowed visit," the decision maker was required to state that schedule availability led to his decision to see a physician. For "health maintenance visit," the decision maker was required to come to

the physician with no specific disease but to request health-promoting services. For "told to come," the decision maker was required to have received an order or strong suggestion by a non-medical person to come to the physician, and was required to state he was following someone else's instructions.

Data Collection

From January 1 to August 20, 1982, all patient-initiated visits to the author and a variable number of patient-initiated visits to the recruited investigators were conducted according to protocol.

Data Analysis

The data were analyzed to study the correlation between the physician's impression and the decision maker's reason for the decision to see a physician. First, the decision maker's verbatim responses to the question "What made you decide to come for this problem?" were coded into four categories: existence, persistence, health maintenance visit, and told to come. These groups were defined by inspection of the data. For existence, a decision to see a physician was made because of an altered mental or physical state, primarily interpreted as needing medical attention. For persistence, a decision was made because of the duration or worsening of a symptom that was interpreted initially as not needing medical attention. For health maintenance visit, a decision was made for preventive services without specific illness. For told to come, a decision was made because a nonmedical authority advised the patient to seek medical attention. Each response was coded into a category by two different investigators. Any disagreement was reconciled by referral to the original data.

Next, data for each encounter were plotted on a grid in which the *X* axis represented the physician's impression and the *Y* axis represented the decision maker's reason for the decision. The distribution of data and presence of perfect correlation between physician and decision maker were noted. The diagnosis for each encounter in every

square of the grid was listed. It was observed whether medical diagnoses varied systematically from square to square. An empirically based taxonomy of reasons for the decision to see a physician was constructed from these observations.

The frequency of lay consultation was calculated.

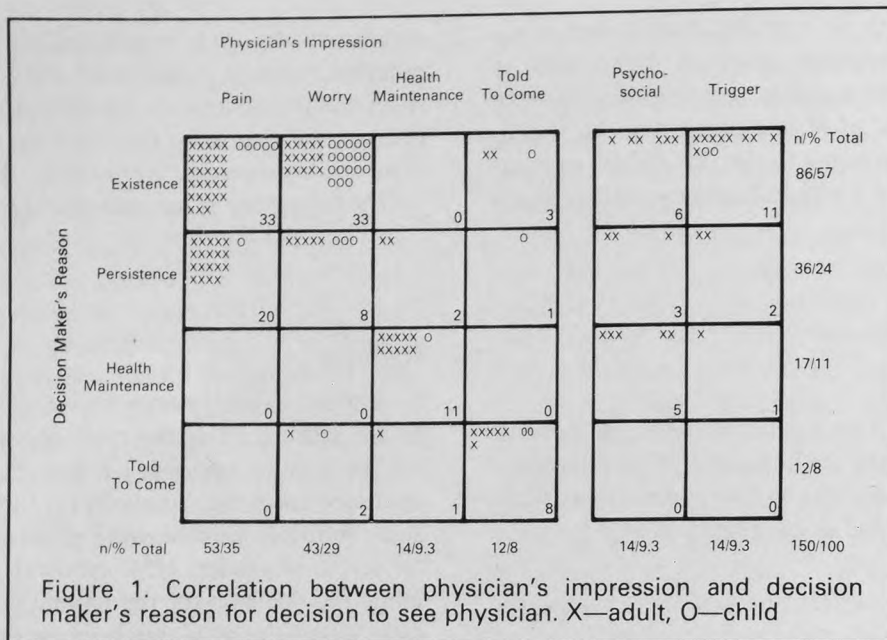
Results

A total of 180 interviews were conducted: 150 by the author, 18 by the recruited resident, and 12 by the faculty member. Thirty encounters were excluded from data analysis for the following reasons: multiple reasons were given for the decision to see a physician (15), medical personnel had made the decision for the patient (11), and insufficient data were available because the protocol was incompletely followed (4). Thus, the data from 150 visits made by 135 patients were analyzed. Of the 150 visits, 123 were to the author, 16 to the recruited resident, and 11 to the faculty member.

Decision makers ranged in age from 13 years to 89 years with a mean age of 37.8 years and a median of 32.5 years. Seventy-four percent of the sample were female, 26 percent male; 58.6 percent were black, 40 percent white. Black women made up 45.3 percent of the sample, white women 28.7 percent; black men made up 13.3 percent, white men 11.3 percent. Demographic characteristics for the sample of patients interviewed by each physician did not vary substantially.

Correlation Between Physician's Impression and Decision Maker's Reason for the Decision to See the Physician

Fifty-seven percent of patients stated that the existence of a problem prompted their decision, 24 percent cited its persistence or worsening, 11 percent chose to come for health maintenance, and 8 percent because someone told them to come. Physicians felt that 35 percent of the patients decided to come because of pain, 29 percent because of worry, 9.3 percent for health maintenance, 9.3 percent for psychosocial reasons, 9.3 percent for specific onset of new problems, ie, trigger, and 8 percent because they were told to come (Figure 1).



There was perfect correlation between the physician and the decision maker in 40 percent of cases. Agreement was most complete when patients presented for health maintenance visits. Disagreement was most complete when patients said someone told them to come or when they presented with psychosocial problems or a trigger to seek medical attention.

There was a distinct pattern of correlation between physician's assessment of pain or worry and decision maker's reason of existence or persistence. The decision maker's reason of existence correlated equally well with the physician's assessment of pain or worry. The decision maker's persistence correlated better with the physician's pain than worry.

For the 36 pediatric encounters, there was perfect correlation between physician and decision maker in 11. Nineteen of the pediatric encounters were assessed as worry by the physician and as existence by the decision maker. In one pediatric case, the physician's assessment was pain, and the decision maker's was persistence. Triggers were the reasons for the decision to see the physician in two pediatric cases, and "told to come" in five pediatric cases.

Disagreement occurred in two cases in which patients presented with chronic problems at the

time of the first encounter for physical examinations (classified as persistence by decision maker and as health maintenance by physician). Disagreement occurred in one other case involving told to come.

Two patients decided to see their physician because of reasons not classifiable in the protocol. One came because of curiosity and the other because she wanted antibiotics. One patient said she decided to see a physician because her schedule allowed a visit.

The Decision to See a Physician for Specific Medical Diagnoses

It was found that similar medical problems were grouped together in each square of the grid (Figure 2). For example, problems that rapidly exceeded the patient's tolerance of physical discomfort were classified as pain by physician and existence by decision maker. Cystitis or abdominal pain presented this way. Mildly painful problems that became more painful were classified as pain by physician and persistence by decision maker. Trauma to an extremity or streptococcal pharyngitis presented this way. Caretakers of children or patients

		Physician's Impression			
		Pain	Worry	Health Maintenance	Told To Come
Decision Maker's Reason	Existence	Problems rapidly exceeding patient's tolerance of physical discomfort (eg, cystitis, abdominal pain)	Caretakers or patients with specific worry (eg, child with fever, breast lump)		Faulty symptom interpretation
	Persistence	Mildly painful problems that grow more painful (eg, trauma to extremity, strep throat)	Persistent, nonpainful, abnormal state (eg, rash, persistent cough)	"Checkup" for chronic problem	Faulty symptom interpretation
	Health Maintenance			Health maintenance	
	Told To Come		Unwilling to seek care	Unwilling to seek care	Told to come

Figure 2. Correlation between physician's impression and decision maker's reason for decision to see physician

with a specific worry but without pain were classified as worry by physician and existence by decision maker, eg, child with fever or woman with asymptomatic breast mass. Persistent, nonpainful, but abnormal, conditions were described as worry by physician but as persistence by decision makers, eg, skin rashes, or persistent coughs. Health maintenance visits often presented without ambiguity, but more than one third of psychosocial problems presented as health maintenance requests. Patients in the trigger group had medical problems identical to those of patients in the pain-existence, worry-existence, and worry-persistence groups.

Told to Come as Reason for the Decision to See a Physician

Of the 15 cases involving told to come, there

was perfect correlation in eight (53 percent). Examination of the other seven cases revealed that three patients were unwilling to seek care and had to be convinced (by their wives) to be examined. Four were unable to make the interpretation that their symptoms warranted medical attention and sought medical care only when a close social contact made the interpretation for them. For example, one 35-year-old man complained of chest pain and was told by his boss to see a physician because he observed the patient working slower than usual.

Psychosocial Reasons for the Decision to See a Physician

The patients who were felt by the physician to have psychosocial reasons for the decision to see a physician formed a group with different demo-

graphic characteristics than the sample group as a whole. Compared with the sample group, the psychosocial group was composed predominantly of white (71 percent) women (86 percent) who were separated from their spouse (65 percent). The sample group was 40 percent white, 74 percent female, and 23 percent separated from spouse. The mean age of the psychosocial group was 43.9 years compared with 36.3 years for the sample group. These decision makers described their reason for the decision to see a physician in the same way as patients with organic problems, ie, existence, persistence, or health maintenance. None said they were told to come. Six of 14 were felt to have frank psychosocial presentations, and there were two with ticket behavior, and six with signal behavior as defined by the protocol.

Lay Consultation

Thirty-six percent of the sample group used lay consultation, 62 percent did not, 1.3 percent were not recorded. Of the patients consulting with someone about the decision to see a physician, the decision maker's spouse was most frequently consulted (39/54), parent next (13/53), and other authority third (7/54). Of note is that no one used books, periodicals, television, or radio to help in the decision to see a physician.

Discussion

Illness behavior is a sociological concept relevant to family medicine. The decision to see a physician is one aspect of illness behavior. In 1972 McWhinney⁴ presented a taxonomy of reasons for the decision to see a physician based on personal recollections of his medical practice. He hoped to help physicians understand their patients and thus provide better care. His taxonomy was never empirically proven. This study provides empirical clinical observations that support the creation of a new taxonomy (Table 1). In contrast to McWhinney's, this taxonomy provides a concrete differential diagnosis of the answer to the question "Why is the patient consulting you now?"

This taxonomy contains eight reasons for a

patient-initiated decision to see a physician: symptom existence causing pain, symptom existence causing anxiety, symptom persistence causing pain, symptom persistence causing anxiety, health maintenance visit, psychosocial reason, told to come, trigger event. Certain medical diagnoses are associated with each of the first four reasons. Health maintenance visits are often unambiguous. Psychosocial reasons are elicited by the physician after the patient has presented with other reasons for the decision to see a physician. Patients who are told to come are following the recommendations of a recognized authority, most often their wives. Trigger events are recalled by some patients as the reason for seeking out a physician. More than one half of pediatric encounters in this study were made because of symptom persistence causing anxiety in the parent.

For the student and investigator of the science of family medicine, this taxonomy provides an empirical skeleton on which to arrange observations of this aspect of illness behavior. Without an empirically based taxonomy, observations cannot be ordered; without organized observations, hypothesis generation is unsubstantiated; without hypotheses, there is no science. Thus, this taxonomy is a contribution to the clinical science of family medicine.

Several interesting observations emerged from this study that help explain how people decide to see a physician. First, physician and decision maker described different dimensions of the experience of illness when explaining the decision to see a physician. Decision makers described their symptoms in terms of time duration, whereas physicians described symptoms by type of problem. The type of symptom was expressed over time; either pain or anxiety could be acute or persistent. This relationship explains the clustering of data in the pain-existence, worry-existence, pain-persistence, and worry-persistence squares of the grid in Figure 1. Psychosocial problems showed no systematic variation according to time duration; they were distributed evenly among the reasons existence, persistence, and health maintenance.

Second, two reasons that people with symptoms warranting medical attention decide not to see a physician were suggested: unwillingness to seek medical care, and inability to interpret symptoms accurately. Further studies would be useful to substantiate these observations.

Reason	Definition
Symptom existence causing pain	Symptom producing pain regarded as requiring prompt medical attention
Symptom existence causing anxiety	Symptom producing anxiety regarded as requiring prompt medical attention
Symptom persistence causing pain	Symptom initially regarded as not requiring medical attention but which persisted or worsened, causing pain
Symptom persistence causing anxiety	Symptom initially regarded as not requiring medical attention but which persisted or worsened, causing anxiety
Health maintenance visit	No symptoms of disease; primary concern is for health promotion
Psychosocial reason	Behavioral problem presenting as organic pathology
Told to come	Patient relinquishes responsibility for illness behavior to someone else
Trigger event	Specific event recalled as the precipitant for the decision to see the physician

Finally, lay consultation was observed much less frequently in this study than in the study by Suchman,³⁸ and no one admitted being influenced by the media in deciding to see a physician. The definition of lay consultation in this study was restricted specifically to the decision to seek medical care; other studies have used much broader definitions. For this reason, comparisons to other literature are hard to interpret.

With exceptions,^{18,30,39} prior studies of illness behavior have used retrospective surveys or health diaries for gathering data. The prospective design of this study and the use of operational definitions in the interview protocol offered at least two advantages over these techniques: (1) objective observations could be made as close in

time as possible to the process being studied, and (2) the physician-patient relationship encouraged open communication and facilitated assessment of psychosocial reasons for the decision to see a physician. The uniqueness and homogeneity of the psychosocial group suggest that discrete patterns of behavior were in fact classified by the interview protocol. These facts support the reliability of the data in this study.

Several objections to these data could be raised, however. There was no way to verify that the protocol questions actually measured the decision maker's real motivation for deciding to see a physician. Variables affecting the decision, but not consciously recalled, such as childhood experiences or cultural determinants, could be measured

only by clinical inference. In addition, the hidden agenda may be difficult to elicit in a single interview, as suggested by Balint.⁴⁰

To allow meaningful comparisons between clearly definable subsets of the sample, patients with multiple reasons for the decision to see a physician were excluded. Analysis of their decisions with this taxonomy might demonstrate them to fit into more than one category at the same time, eg, symptom existence causing anxiety plus trigger event. Further research to clarify these relationships is needed.

In summary, this study demonstrates a method for family physicians to investigate the illness behavior of their patients. The observations made in pursuit of the question of why people decide to see a physician provide the basis for an empirical taxonomy to classify one aspect of illness behavior. This information is useful to the practitioner and contributes to the growth of family medicine as a clinical science.

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