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Review Article
Published: 26 Jan, 2018

Journal of Family Medicine Forecast

Presentation and Approach of Disorganized Disease in Family Medicine

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Abstract

Patients of the general practitioner do not fit adequately into the traditional diagnostic categories. In family medicine it is necessary to evaluate the presentation of the symptoms, in addition to the symptoms themselves. Symptoms are the result of an interpretation process. Most patients treated in family medicine have disorganized diseases: they are symptoms or problems that are not fully developed or open in the interview, and give the doctor a feeling of confusion, disorder, restlessness, uncertainty, insecurity with respect to the traditional diagnostic categories, and at the same time expectation. There is evidence, both statistical and anecdotal, that many major diseases are preceded by periods of unhappiness and disorganized disease. This adds further emphasis to the important responsibility of the general practitioner at this early stage of disorganized disease. Among the symptoms or reasons for consultation, in one or several visits may appear a detail, such as a sudden revelation. Here "seeking an order" refers to "seeking a meaning" to establish harmonious relationships. We do not care about disorganization, because family doctor, as the artist does, he have already agreed to work outside the normal order; the atmosphere of symptom presentations where the family doctor works is one that has a preference for disorganized places, and the modus operandi of the family doctor is similar, since he uses "disorganized" methods: faces dark subjects, casual data, therapeutic tests and anecdotal observations, and relies on decisive moments. Here family doctor seeks a "plastic" order, and not the reproduction of a biological orthodox aspect.

Keywords: Family Practice; Symptom Assessment; Complexity; Diagnostic Techniques and Procedures; Physician-patient relations; Communication

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Received Date: *17 Oct 2017*
Accepted Date: *15 Jan 2018*
Published Date: *26 Jan 2018*

Citation: *Turabian JL. Presentation and Approach of Disorganized Disease in Family Medicine. J Fam Med Forecast. 2018; 1(1): 1001.*

ISSN 2643-7864

Introduction

Patients of the general practitioner do not fit adequately into the traditional diagnostic categories

The general practitioner, as the first contact, is formed mainly in basic sciences; their medical professors are basically specialists with natural bias towards their own specialties. It is not surprising, therefore, that the novice general practitioner has experience in hospital medicine, but that he finds that many, if not most of his patients do not fit adequately into the traditional diagnostic categories, and it is not easy to choose the right treatment, so that many general practitioners are frustrated by their inability to "do something" for these people. Further, many patients have symptoms without disease or have self-limiting diseases that do not require any intervention, or chronic diseases that can not cure (according to the traditional sense of healing, by definition). Some physicians develop intuitive methods to deal with this problem, others simply ignore it, but few doctors feel comfortable treating patients to whom "disease-centered" medicine has little to offer [1]. To change the "mental computer processing unit" of hospital care, the family doctor has "to go to the border and, from there, look at the territory that it has left".

"Presentation" of the symptoms

In family medicine it is necessary to evaluate the presentation of the symptoms, in addition to the symptoms themselves. That is, the reason for the consultation begins or emphasizes important issues for the patient, and not just symptoms, in a context of communication [2]. The same symptoms give rise to different "presentations of the symptoms" (how the patient counts his symptoms).

Family doctors see patients (people) who experience and live their symptoms in a personal way. In textbooks the symptoms are conceived as expressions of defined organic alterations. Students learn to recognize illness by becoming familiar with patient prototypes, but family physicians never see symptoms that correspond exactly to those prototypes, but symptoms that are experienced by

BOX 1: Two classic ways to classify the types of consultations family doctor sees on a normal day of work.

CLASSIFICATION 1
-65%. Self-limited diseases, -20%. Chronic diseases with multimorbidity, -15%. Acute diseases.
CLASSIFICATION 2
-20-30%. Without disease: when the person presenting himself as a patient does not have a situation suggestive of illness. (Preventive visits, pre and postnatal visits, vaccinations, health examinations, etc.). -10-20%. Organized disease: When doctor and patient they agree. in a diagnosis, organic or psychological, and the doctor-patient relationship is more or less oriented around the disease. -50-70%. Disorganized disease: The majority of the patients are treated in family medicine.

BOX 2: Some of the possible criteria for symptoms / disordered problems/diseases.

1.-Presentation of complaints in an unorganized way from the biological point of view.
2.-Feeling by the doctor of "inability to do something" for these people.
3.-The symptoms are sufficiently annoying for the patient to listen to himself and go to the doctor, although his problems do not seem to reflect a severe pathology.
4.-In these visits the discomfort and the psychological regression arise from the beginning. Balance is threatened, and regression to infant models occurs when the individual is threatened by external pressures or by his internal psychopathology.
5.-When doctor and patient are not of agreement in a diagnosis, organic or psychological.
6.-When the doctor has the intuition or feeling that there is hidden data that should come to light.
7.-When several medical problems are treated in a patient (eg, peptic ulcer, anorexia, depression ...), but there is no way to explore an overall diagnosis that of order to the whole.
8.-When it is not clear if the patient is who make the consultation or another member of their environment.
9.-When doctor-patient relationship is not oriented around the disease.

humans trying to communicate their discomfort or concern with signs that start from their own bodies [3].

Symptoms are the result of an interpretation process. Symptom experiences are embedded in a complex interplay between biological, psychological and cultural factors. The expression of symptoms depends more on psychosocial aspects than biological. In consequence there must be a variety of interpretations of sensations, which are not equivalent to expressions of underlying disease [4]. The symptoms expressed by patients in the consultation (especially in family medicine, can have different meanings: expressions of biochemical alterations, symbolic expressions, expressions of the group context, expressions of family stress when going through developmental transactions, expressions of coping with a situation or event, expressions of "family character or style" symptoms, somatic expressions associated with mental problems and functional or psychosocial expressions associated with organic problems, or social and historical expressions [5,6].

One of the main elements of the clinical competence of the family doctor is the understanding of the "presentation" of the symptoms: personal communication of a change within the experience of his own body, not a sign or indicator of illness. The "presentation" of symptoms is a personal communication of a very private experience. It is impossible to separate the message from the way it is given. The problem in family medicine is to assess the significance of symptoms for diagnosis [7].

Qualitative symptoms and diseases, which "are and are not" at the same time

Another characteristic of symptoms and diseases in family medicine is the fact that not all they can be categorized dichotomically into "are" or "are not" (as if in a fracture or a stroke, for example). Diseases and symptoms in family medicine tend to be "qualitative" and depend on qualitative variations, such as hypertension, where BP values have a continuous distribution in the population. Or in depression, where there is an aetiological continuum that prevents us from marking a point from which we consider a depression to be caused only by internal or environmental factors, and there is a continuum between anxiety and depression that makes it difficult in practice at time of the diagnosis, to choosing between anxiety or depression, and there is a continuum between "normal" and "abnormal" (case and non-case), so the distinction in practice often depends on the instruments used and of the definition of "cut-off point". Many other diseases are "deviations from the mean", in addition to hypertension: obesity, airway obstruction, diabetes mellitus, hypercholesterolemia, alcohol abuse, tobacco, chronic low back pain, etc. Moreover, in these problems, their psycho-social connections are clearer and more important [8,9].

Thus, there is a third classification: "it is", "it is not", and "it is and is not" (or put another way, they are disorganized). In the hospital, medical specialists "detest" (possibly rightly in that context) the qualitative disorganized disorders with social connections, so that these problems become the task of the family doctor.

Disorganized symptoms and diseases

Due to the different ways of classifying the types of consultations that a general practitioner makes, we may have different perspectives. BOX 1 presents two classic ways of classifying the types of consultations that the family doctor sees in a normal day of work [3].

Between 50-70% of the patients treated present disorganized symptoms or diseases; therefore, account for the majority of patients cared for in family medicine.

What are disorganized diseases? It is those symptoms or problems that "give the doctor a feeling of confusion or of a disorder that is not fully developed or open in the interview", and give the doctor a feeling of confusion, disorder, restlessness, uncertainty, insecurity with respect to the traditional diagnostic categories, and at the same time expectation about its evolution. BOX 2 presents some of the possible criteria for disorganized symptoms/problems/diseases.

Of course, within the concept of disorganized diseases can be included the list of the most common diseases difficult to diagnose whose symptoms are nonspecific and variable, such as irritable bowel syndrome, celiac disease, fibromyalgia, rheumatoid arthritis, multiple sclerosis, appendicitis, Lyme disease, lupus, Syndrome of polycystic ovary, Hypothyroidism, etc. However, the "disorganization" of symptoms and diseases has its true character at the biopsychosocial

BOX 3: Two simple examples of "deorganized presentations of symptoms/problems".

1. A 36-year-old woman with four children brings her 14-year-old son, who has been with cold for several days, to the practice and says, "Would you mind looking at my nose too? I've had some bleeding this summer. " And shortly afterwards he says: "My husband is still not well; still drinking and there are disputes ... The children are nervous, and nothing is going well ... ". The intervention option can be to focus on your emotions, fears, feelings, communication problems ..., exploring if you can the real point of alteration to one or several levels, and see if the situation could be redirected, and less on acting on the cold of your child, or your epistaxis (traditional diagnosis). The subsequent deterioration of the family balance could lead to an organized disease, which can take many forms.
2. A woman of 53 years frequently visits to family doctor for voiding syndrome with negative urine cultures, as well as vaginal smears; she has been visited repeatedly by urologist and gynecologist without finding pathology. No treatment relieves her. There is an abuse of antibiotics. Visit to various specialists in public service and private consultations. In their visits, there are also consultations for migraines, allergic rhinitis, and ulcerative dyspepsia. She is separated and the situation with her current partner seems acceptable, but there are relationship difficulties with her child. There are also work problems. Expresses your urinary symptoms intensely; she cries because her problem is not understood by doctors; she "is in a dead end", but rejects that its problem is in the psychological sphere. Subsequent evolution may be directed to a biological diagnosis (such as interstitial cystitis), and / or to psycho-social problems.

level: it is biopsychosocial disorganization, not only due to unspecific biological symptoms. The subsequent deterioration of the biopsychosocial balance can lead to an organized disease, which can take many forms.

There is much evidence, both statistical and anecdotal, that many major diseases including cancer are preceded by periods of unhappiness and disorganized disease. This, if true, adds more emphasis to the important responsibility of the general practitioner at this early stage of disorganized disease [10]. BOX 3 shows two simple examples of "disorganized presentations".

Conclusion

The modus operandi of the family doctor is also a disorganized method

The atmosphere of symptom presentations where the family doctor works is one that has a preference for unhappy or unpleasant or disorganized places, or those aspects of human nature that are most remote ... These places disorganized, "ugly" or "dirty" are like the interior of certain rooms like the dining room or the kitchen, showing a messy set of objects, perhaps old or broken furniture or various styles of them, or dirty dishes, empty bottles ... which reflect the love and hate of the residents of those rooms.

But the modus operandi of the family doctor is similar, since he uses "dirty" methods; faces dark subjects, casual data, therapeutic tests and anecdotal observations, and relies on decisive moments. What contributes to the greatest glory of family medicine is not innovation in the available tool and efficiency (which we can leave to the manager, the bureaucrat, or the computer), but also in the depth of feeling. As family physicians we are involved in the relationships and images they provide.

A tip for family doctor with less experience is to forget the diagnosis and treatment. A decision on diagnosis and treatment will occur, but family medicine is actually about relations and people management. It is about helping the sick through the borders of their fears and doubts and deep wounds, about managing the incalculable steps of the unexpected. Do not misunderstand. Family doctors are grateful to the tools that have given us clinical-knowledge, discipline, and drugs that sometimes work. But we must also recognize that the center of academic medicine is a monolith of truth and knowledge construction that simultaneously reveals a dark area influenced by unknown forces and powerful biases. The achievements of family medicine are like the photos of certain photographers — often not totally clear or nice or well composed-, but they reveal the virtues of human beings, the relationships that are formed, and the set of chaotic and disorderly elements that pile up in clinical data, including those that are projected by own doctor [11,12].

How to intervene in disorganized symptoms or problems?

Patients' needs may not be expressed in words, and they have to be discovered by the doctor's diagnosis and even intuition. The vital role of the general practitioner is in the interpretation of the unexpressed calls for help. To satisfy the patient is not simply to satisfy the expressed desires, but to meet the deepest, sometimes unconscious needs, and this requires complex and refined techniques [1].

Disorganized presentations cause restlessness and excitement in the doctor. Among the symptoms or reasons for consultation, in one or several visits (sometimes after many visits) may appear a detail, such as a sudden revelation, an illumination, and a voice tells us "this is your true path", as in the fall from Saul's horse on the way to Damascus [13].

This "flash" is not a new magic tool, but simply a kind of doctor-patient relationship. When we are aware of something that arises abruptly, and it gives rise to a new understanding between both. It is not the panacea, nor a new form of treatment. It is completely included in the normal general practice consultation, based on the tools that it usually is uses at this level: knowledge and the ongoing relationship with the patient. The "flash" is the mutual or sudden mutual intuitive appreciation or recognition, shared between doctor and patient, of an important understanding, that allows focusing the total diagnosis, which could not have been achieved by other methods [14,15].

The doctor's job is to make these details, these revelations be more visible: What will there be beyond? The family physician must go from the centrality of the patient's presentations to the periphery, exploring and investigating that secret or hidden order of symptoms; the doctor, as an architect must be creating an orderly, habitable place for the patient [12]. Here "seeking an order" refers to "seeking a meaning" to establish harmonious relationships. We do not care about deformation, because in family medicine, as the artist does, we have already agreed to work outside the normal order to put ourselves in an different aesthetic order; it is about making a new "plastic" order, not the reproduction of a look of traditional diagnostic categories [16].

The physician seeks cross-connections between symptoms or problems; he looks for the secret interstices among those disorganized multi-problems. To exit the maze, we must find the "Master Issues" or problems with "energy" -are those what gives us a blow to the stomach, which makes us faster tin heart, that moves us on many levels. This type of problem has a great "density of emotions", human elements, social symbols; it is complex, multiple and dramatic or theatrical. The medical history is articulated as a stage; all things lead to a certain point. As we look, for example, The Kiss of Judas, Giotto di Bondone, 1302-1305, cool in the Scrovegni Chapel in Padua [17].

Within the complexity of the case, we will have to recognize or

discover the basics: it would be like removing the 'figurative' and discover the 'composition'. By means of contextualizing and reflecting on the essence and the peripheral, we can approach the details or the "geometry" system that defines the problems, and finally to the "signs and symptoms" and their "spirit". It is like seeing between the lines, such as a constructive composition painting [16]; the disposition of the notes in a musical score: a mysterious constellation. This is, therefore, a qualitative method to facilitate the application of decision-making tools in patients with presentations of disorganized problems in family medicine [18]. It is about leaving the accessory, the conjunctural. Focus first on the "structure" of symptoms, and then on "geometry"; decomposing reality into levels to reorder it into an organized set.

The hospital doctor has to justify his diagnosis by the investigation (complementary tests, analytical, tests of image, etc.). However, the general practitioner has to justify his investigations by his diagnosis [10]. The same evidence does not have the same weight for each context: it may be appropriate in one context, but not in another. Therefore, the interpretations of "true" and "false" have to be modified. A conclusion may be "sufficiently true" in one situation, but not in another [19]. Signs and symptoms are nothing more than an illusionistic reflection of a higher, more essential reality; as if the signs and symptoms were hieroglyphic that the doctor must decipher to see them better.

References

1. Philip Hopkins (Editor). Patient-Centred Medicine. Based on the First International Conference of Balint Society in Gran Britain on "The Doctor, His Patient and the Illness", held on 23rd-25rd March, 1972 al the Royal College of Physicians, London. London: Regional Doctor Publications Limited.
2. Rudebeck CE. The clinical method of general practice. Scand J Prim Health Care. 1991; (supple 1): 30-39.
3. Turabian JL. [Family and Community Medicine notebooks. An Introduction to the Principles of Family Medicine]. Madrid: Díaz de Santos. 1995.
4. Turabian JL .Is The Meaning of Symptoms the Same in Women And Men? J Women's Health Care. 2017; 6: 376.
5. Rosendal M, Jarbøl DE, Pedersen AF, Andersen RS. Multiple perspectives on symptom interpretation in primary care research. BMC Family Practice. 2013; 14: 167.
6. Turabián JL, Pérez Franco B. The symptoms in family medicine are not symptoms of disease, they are symptoms of life. Aten Primaria. 2012; 44: 232-236.
7. Morrel D. The Art of General Practice. Oxford: Oxford University Press. 1991.
8. Perez Franco B, Turabian JL. Is the Orthodox Approach to Depression in Primary Care Valid? Aten Primaria. 2006; 37: 37-39.
9. Turabian JL. Relatos clínicos musicales de medicina de familia. Desarrollando las capacidades humanísticas de los médicos de familia mediante el arte. Saarbrücken, Deutschland: Editorial Académica Española. 2016.
10. Browne K, Freeling P. The Doctor-Patient relationship. New York: Churchill Livingstone. 1976.
11. Loxterkamp D. Saving Fred: what family practice means to medicine. BMJ. 2000; 321: 1567-1568.
12. Turabian JL, Perez-Franco B. The Family Doctors: Images and Metaphors of the Family Doctor to Learn Family Medicine. New York. Nova Publishers; 2016.
13. The holy bible, new international version. Saul's Conversion. [homepage on the Internet].
14. Enid Balint, J.S. Norell (Ed). Six minutes for the patient: interactions in general practice consultations. London: Tavistock Publications. 1973.
15. Arshad MS, Paton RW. 'The psychological problem is looking at you, are you looking for it?': psychological associations with symptomatic musculoskeletal referrals. Scott Med J. 2017.
16. Between the lines: Joaquín Torres-García's constructive composition. Art Museum of the Americas. Washington, DC 20006. 2013 [homepage on the Internet].
17. Giotto. Wikipedia. [homepage on the Internet].
18. Turabian JL, Perez Franco B. A way of helping "Mr. Minotaur" and "Ms. Ariadne" to exit from the multiple morbidity labyrinth: The "master problems". Semergen. 2016; 42: 8-48.
19. Turabian JL, Franco BP. Responses to Clinical Questions: Specialist-Based Medicine vs. Reasonable Clinic in Family Medicine. Integr J Glob Health. 2017; 1: 1.