

14 What Does the Primary Care Physician Do in Patient Care That Makes a Difference? Five Approaches to One Question

MARTIN J. BASS
HOWARD BRODY
CECIL G. HELMAN
JOHN G. R. HOWIE
HENK LAMBERTS
PETER G. NORTON
BARBARA STARFIELD

As a final topic for this volume, Martin Bass posed a question: "What does the primary care physician do in patient care that makes a difference?" Drs. Starfield, Brody, Helman, Lamberts, and Howie each agreed to formulate a research agenda around this question.

Their responses, which follow, are what one would expect: individual, perceptive, insightful, and innovative. Dr. Starfield, an epidemiologist, presents a summary of her generic approach to any research question, and then highlights this approach by considering aspects of the posed question. She focuses on the issues of question, population, hypothesis, measures, and interpretation. Dr. Brody, a philosopher as well as a clinician, grapples with the meaning of the question itself. He models for the reader the necessary steps for creation of a research question from a general question, such as the one posed here, and struggles to link his convictions about the meaning and goals of primary care with his recent readings. Through this process, he emerges with

In Norton, P.G., Stewart, M., Tudiver, F., Bass, M.J. and Dunn, E. (1991) *Primary Care Research: Traditional and Innovative Approaches*. 209-220. Newbury Park, CA: Sage Publications.

a brilliant primary care research question. Dr. Helman, an anthropologist and a clinician, invites us to consider the question from three patient and physician viewpoints (a "triplopia"): attitudes, behaviors, and physiology. Dr. Lamberts (1987), a clinician and director of a multipractice registration study in the Netherlands (the Transition Project), explains how the database that resulted from his project could be used and enhanced to answer the question. His approach is to examine the intersection of patient values and doctor norms by assessing the main reasons for encounter as viewed by each party.

Finally, Dr. Howie, an academic family physician, stresses that a research question must be, as well as answerable, interesting and important to the investigator. In particular, he cautions that the appropriate tools must either be available or be developed. He translates the general question to a specific one that is different from any that the others posed.

These five responses can serve as role models for us by displaying different and diverse specific questions, research methods, and acceptable standards. It could be argued that to answer such a question, one that is central to primary care, multiple specific questions must be addressed and that each question may need its own methods and standards.

DR. BARBARA STARFIELD: What I am going to do is explain five principles that guide me in my own research and in research consultation.

The first point, regardless of whether a question is my own or somebody else's, is why in the world is the question being asked? Let us take the proposed question in particular: "What does the primary care physician do in patient care that makes a difference?" There are many reasons why this question may have been posed. Let us suppose the reason is that we feel defensive, are concerned about future funding for primary care, and want to set up a study that will influence the people who are responsible for policy decisions. As you can see, you really have to be clear why you are asking the question in order to narrow the framework for the study.

The second point is to consider what the question is really about, what is implied about the population that will be studied. You have to get a clear understanding of the definition of the proposed study population.

The third component is the hypothesis. In research it is not always necessary to have a hypothesis; rather, it is possible to conduct studies whose aim is to *generate* hypotheses. However, if a proposed study does have a hypothesis, it must be out in the open, since its statement will help decide what variables need to be in the equations and what data will be collected.

The fourth thing to be considered is the data source: Do you have access to the data, or must you collect it? If some of the data needed are not available (e.g., you cannot recruit patients), then you will not be able to answer even the best posed question. Consider the specific question again: What does a primary care physician do in patient care that makes a difference? The operational terms here (the variables) are *do* and *difference*. What is meant by "do"-what kind of things are included? Is the important thing problem recognition, diagnosis, therapy, reassessment, or something in another framework? The researcher has to consider the question, "What do you mean by 'do'?" It is the same thing with "difference"-what kind of things are you going to consider important in making a difference?

Going back to the general case, you must also consider what things you will be able to measure. Limitations include your skills, the instruments at hand, and available resource people. Similar limitations apply to eventual analysis: If you have only certain skills yourself, or if only certain skills are available to you, there is no point in setting up a design that you just cannot deal with.

The fifth and final point centers on the interpretation. This brings us full circle and back to the question. What kinds of interpretations are you going to be willing to put on your data? Are there certain findings that would be so unacceptable that you would not be willing to spend time and energy on a study that might reveal these findings? I think this is a very important consideration.

These five points are a framework that I would use in considering this question or in counseling somebody who proposed it.

DR. HOWARD BRODY: I cannot reply to the question as it was posed, because I think I know the answer. I will, however, at the end of my remarks, discuss a related question that could be researched. I think it interesting that, since I think I know the answer to the posed question, if someone did a research project and got a different answer, I probably would not believe it. I am going to tell you what I think the answer is, rather than describe how I would do the research project.

One attractive answer to this question, what does a family doctor do in patient care that makes a difference, was provided by John Berger in the book, *A Fortunate Man* (1976). There were two things in this book that, to me, seem to describe this: *recognizing* and being the *clerk of records*.

Recognizing is a technical term that Berger, a sociologist, defines as follows: Anguished patients (not just sick, but truly anguished) are somehow convinced that they are no longer part of the human community. They feel that their illness has made them so different that they are not recognizable as people. They come to the physician, offering their illness, fully convinced that they cannot be recognized as people anymore, but hoping that at least their illness might be recognized. Berger says that recognition has occurred when the family physician succeeds in meeting this expectation. In doing so the doctor reestablishes the bridge of humanity, and the patient once more feels part of the human community. In essence, the physician reaches out to the patient and says, "I recognize what is human in you, that you have been so anguished about the illness that you have forgotten that humanity is still there in you. My humanity reaches out and recognizes the humanity that you still have."

The *clerk of the records* concept describes how the physician engages in the conversation of the community at a pub or local gatherings. This idea centers around the importance of the physician as one who validates communal knowledge and memory. Berger observes that many conversations between physicians and patients begin with "do you remember when?" The scientifically trained physician, as a member of the community, validates everyone else's memories and confirms, "Yes, it did happen that way." This is, however, a very humble role; the physician is not an archbishop but merely a clerk of the records, invited in only at the will of the members of the community to carry out the humble but important function of validating their records.

It is interesting to look at these two functions for two reasons. First, they are both social bridging functions, and second, the themes that run through both of them are wholeness and coherence. Because they involve these reasons, I find them attractive answers to the question of what do we family physicians do that is important.

I have recently been trying to incorporate these concepts into my work and have developed a framework that I call the joint construction of narrative. The model claims that the generic feature of a patient's presenting complaint is, "My story is broken. Can you

help me fix it?" Usually there is more: "I think I have a story, but it scares me and I do not like it. The story that I am telling myself is a dysfunctional one and I can't live comfortably with it. Doctor, help me construct a better story that will cause me less discomfort and distress." In an extreme case the patient might mean: "I cannot tell myself a story." My concept is that the family physician has to listen carefully enough to know the patient's story and determine whether it is functional or not from the patient's perspective; and then, using medical knowledge and models of prevention and treatment, help construct a new story that is recognized and can be owned by the patient.

That was what I thought the answer was when I came to cooperate on this book. But, I must confess that I am a bit puzzled. My puzzlement has arisen from a number of things that I was either reminded of by the other chapters or read here for the first time. One thing that struck me was Donna Manca's paper on women's accounts of their miscarriages (Chapter 11). The qualitative design got at the experience of miscarriage and its value to women: what was good, what was healing, and so on. One woman's comment to the interviewer was very revealing to me: "This was the first time I have had a chance to tell my whole story. Other people have asked me for specific pieces of my story, based on what they were concerned with, but this is the first time I have had a chance to tell the whole story" (Manca, 1989).

Thinking about this has led me to be more humble. I might have to give up the idea of the joint construction of narrative. I wonder if what attracted me to it was physician activism.

Let me hypothesize a new model. Doctors like to think they are doing something. In a consultation, the important thing is that the doctor listens and the listening is what really does the work. If the doctor "fixes the narrative" later, it might be that the patient gives it back to make the doctor feel good. What really was therapeutic, what really made a difference, was the listening to the story.

That is, to me, the interesting research question. Of course, the answer could be a bit of both my old idea and my new model. In the short run what I do that makes a difference is to listen to the story. However, in the long run what I might do is help fix the story. That is my hunch and that is my research agenda.

DR. CECIL HELMAN: One of my ideas has already been discussed by Dr. Brody. As an anthropologist, I was going to say that the important thing is that family physicians are healers. It is interesting to

compare family physicians to other healers in other locations: in other cultures, in hospitals, in the community, and so on.

Healers in all cultures and backgrounds have certain things in common. While they heal the body, mind, and spirit, they also do something more subtle and hidden. They try to put Humpty Dumpty together again. (This is similar to what Dr. Brody has written.) They reassemble the patient's worldview.

III health, particularly an acute event, results in physical and psychological symptoms for the patient. But more happens. The continuity and the coherence of the patient's world are shattered for a moment. When a healer listens to the narrative story, the patient's tale is reestablished as part of the bigger story of the world. Healers try to fit the individual's suffering into a wider framework.

Starting from this perspective, one can develop a research agenda for family medicine. The agenda requires that we develop a "triplopia," which involves looking simultaneously at three things. First, we must examine attitudes, beliefs, and narratives in order to understand both what people think and what they say they think. Second, we must look at behavior, either self-reported or observed. Third, we must consider the physiology: what the body says.

This "triplopia" leads to three conceptual views of the patient, each of which may be entirely incompatible with the others. The attitudes, behaviors, and physiology of a patient may run on three different tracks. For example, you could have 10 people all drinking the same amount of beer every day, and yet their individual physiologies might be quite different. So one has to have the conception of multiple perspectives converging on any particular case.

I would also suggest that the research issue include the doctor; that is, that the attitudes, behavior, and physiology of the doctor be studied as well. One must question whether he or she puts together the world-reassembles Humpty Dumpty-during the consultation. In fact, maybe the whole aim of being a doctor or a healer is an attempt to reassemble the shattered Humpty Dumpty within oneself.

I make an appeal. By all means use social science along with quantitative physiological techniques, but move the doctor into the framework with the patient. This will lead to a "reflexive" approach, which is one of the contributions of feminist anthropology. It can be described as dropping the mask-the bogus mask-of objectivity, and being more involved in the situation: admitting one's influences upon it and vice versa.

I will cite one personal example where my research project influenced me (Helman, 1981): where the attitudes, beliefs, and behavior of a group of people whom I studied affected my own attitudes, beliefs, and behavior. Some years ago I interviewed 50 people, both men and women, mostly middle-aged, all of whom had been taking benzodiazepines for a minimum of six months. Conventionally, these subjects would be considered to be "hooked" on their drugs. Every month, regular as clockwork, all 50 would attend their doctors to get their prescriptions renewed for enormous amounts of Valium or Nitrazepam.

When I studied these people, all of whom were being treated exactly the same by their doctors, I found three different metaphors that they used to describe their drug use.

One group saw the drug as a tonic, in that they took it only occasionally and had control over it. These patients would say, "Well, when I need a tonic, I take it. When I feel tense, I take it."

The second group used it as a type of fuel, feeling that without the drug, they wouldn't function in a social way. These people saw themselves as essentially "bad," but with their medication, they were able to fulfill social expectations. This finding was similar to that of the late Ruth Cooperstock (1979) of the Addiction Research Foundation in Toronto. In her study, most of the subjects who were addicted to Valium were women. These women told her, "Without Valium, I am a very irritable and unhappy person. However, with it, I am a nurturing person, a very nice person, and so on."

The third group saw the drug as a food. They were, in the main, elderly. Their view was that without the drug, not only would they be unable to function socially, but they would actually die.

This study influenced my behavior. I understood that, contrary to their physicians' opinions, patients "hooked" on benzodiazepines are not a homogeneous group. I thought that a doctor might be able to tailor the treatment to individual patients. For example, if a patient viewed the drug as a tonic, then it would not be necessary to prescribe a large amount every month. The patient should be encouraged to use the medication only when it was needed. In fact, all patients should be counseled to move toward the tonic end of the spectrum.

In contrast, the group who saw themselves essentially as bad people, who could only fulfill social expectations if they used the drug, would need a different approach. In particular, they should

respond to therapy designed to enhance a stronger vision of themselves and their positions in the world.

The third group, who saw Valium as a food, would be the most difficult of all. One would have to nourish them in another way. These people often felt that, with the drug in their house, they were not alone. They were socially isolated, so tailoring the treatment to them meant trying to break their isolation.

The important research efforts in the future will thus try to unravel patients' and doctors' beliefs and behaviors. The findings will lead to improvements in the way doctors deal with people.

DR. HENK LAMBERTS: I begin with the idea that there is a difference between the subjective values of patients; the more objective, normative approaches of doctors; and the collective norms of society. I would focus on this margin between the values of patients and the norms of doctors, and consider a number of aspects of function: physical, psychological, and social.

I would attempt to ascertain what doctors *really* do for 1,000 patients per year. That is my unknown, and to go on, I would have to know that data. To reliably determine these data, I would set up a routine database that included complete episodes and measures of functional status as seen and assessed by the patient and by the family physician. I would measure it (functional status) objectively, using the COOP charts (Lamberts, 1990).

I would first examine this database by looking for discrepancies: Where do the patient and the doctor disagree? Then I would examine how function changes over time and over episodes, what daily activities are limited in each patient, and the physical and emotional condition of the patient at each consultation. If the patients were suffering pain, I would grade the severity. Finally, I would like to know what patients think about changes in their function and health, and what the doctors think about such changes.

Using this database I would exclude those episodes that had an acute course over time. From the Transition Project, it is known that 50% of new episodes are over with in four weeks (are acute). I would focus on subacute (taking one to six months to resolve) or chronic episodes, so there would be enough time to see whether the doctor's intervention makes a difference. The distribution of the conditions (demo graphics, diagnosis, symptoms, and so forth) for these longer episodes would be determined, to see if it was the same

as that seen in the Transition Project, in order to establish a reference point.

I would probably limit my study to patients 65 years and over. Older patients have many psychological and social problems in addition to their chronic and subacute conditions, and I believe that this combination makes this group one in which family physicians can make the most difference.

For the study population, it would be important to determine the reasons for encounter (RFE). In particular:

- how often such patients initiate an episode with a psychological or social complaint;
- how often the doctor initiates an episode with the reason for encounter being a psychological or social problem.

As an illustration, I hypothesize that family physicians are extremely effective with one subgroup of the study population: those patients presenting with the fear of cancer (or another disease of perceived similar seriousness). In the Transition Project, 9% of patients presented with this complaint in the registration year.

In summary, to study the proposed problem I would work with an ICPC episode-oriented database, with patient- and doctor-evaluated function status added to it. I would concentrate on longer episodes, so that there was time to see important changes that might be attributable to the doctor's intervention. To measure which changes are important, I would use both the doctor and the patient as judges. Routine databases would only elucidate one part of the picture, and I would need specific studies to complement it.

DR. JOHN HOWIE: There is a little fishing village called Cruden Bay, about 20 miles north of Aberdeen. Just south of Cruden Bay there is a crossroads sign, which reads: "Cruden Bay, 5 miles this way," and "Cruden Bay, 5 miles that way." The story is told of an American visitor who had arrived and found himself perplexed at the choice available to him. He asked a passing farm laborer, "Say, my good man, does it matter which way I go to Cruden Bay?" To which the answer was, "Nae to me."

And to me the answer to the question is: "Nae to me." I am afraid it doesn't appeal to me very much. If I were to consider the problem by looking at principles, I would go back to my two sets of principles about interesting and important events. I would have to say

that the question, as it is worded, is not interesting or important to me, and so I would begin by negotiating a more specific question.

I have, by focusing down, managed to persuade myself that the question is potentially interesting and important. In this I have something in common with Dr. Lamberts. I feel that he has discussed almost all points that I wanted to consider. However, I have narrowed down to one single thing which he did not consider and which, if true, would satisfy me with respect to the question "what do family doctors do that makes a difference?"

Not surprisingly, I have focused on the question: "during consultation, does the doctor improve the state of psychosocial well-being of the patient?" I assume that the answer is yes. As a secondary question I am going to ask, "Do quick doctors, as defined in my chapter (Chapter 2), do it less well than slow doctors?" I admit that you could also ask, "Do doctors do it better than nurses? Do nurses do it better than receptionists?" There is a whole variety of related questions.

The question in this form is interesting, important, and answerable. But there is one more of my principles that the question (now rephrased) needs to meet. Can we identify an accessible and definable numerator and an accessible and definable denominator?

The Nottingham Health Profile (Kind & Carr-Hill, 1987) is a self-administered health status measure comprised of two measures of physical health and pain and four of psychological and social health. It has been validated in England, and I assume (this may be questioned) that it is therefore valid in Scotland as well. (There is always a risk in trying to translate a measure from one country to another: The measure may lose some refinement of meaning, and that may make it less acceptable and useful.) I would administer it to patients before they have a consultation and again a month after, to see whether their response had improved. I have narrowed Dr. Bass's question down to a measurement of this effect. In fact, our research group has already started this study, and you will know the answer in the near future. What we have found so far is that about 30% of patients who consult us in our inner-city disadvantaged practice have important psychological or social problems we have missed or have not had time to address.

DR. PETER NORTON: So there you have it. Five different but complementary approaches to the same question. The original question is central to primary care research but was too general, so each of the writers has rephrased it to suit his or her research agenda and

concept of primary care. I think questions such as the one Dr. Bass posed are best attacked by breaking them into researchable pieces. Each piece may require a different research method, and each method will have its own standards and protocols. Some of these methods and standards exist, others will be borrowed from other branches of science, and still others will need to be created as our discipline matures. The use of multiple approaches will be complementary to our practice and the resulting research agenda will help us deliver better and more comprehensive care to our patients.

If we carefully examine the responses to the question proposed above, two factors are apparent. First, each contributor rephrased and focused the question so that it was "owned" and thus became a question to which the investigator could be committed. Second, each contributor has suggested a research method that relied on his or her own individual expertise and experience.

We are generalists, and practice in that condition. We must allow our generalist skills to carry over into our research agenda. We must use the expertise and sophistication of our specialist colleagues, whether in medicine, social science, behavioral science, or any other research discipline, and adapt them with their standards to our unique and important field. This book has attempted to facilitate this vision, and we hope that it will aid and assist all researchers in their attempts to better understand the primary care interface and improve it.

References

- Berger, J., & Mohr, J. (1976). *A fortunate man*. London: Writers and Readers Publishing Co-operative.
- Cooperstock, R. (1979). A review of women's psychotropic drug use. *Canadian Journal of Psychiatry*, 24(1), 29-34.
- Helman, C. G. (1981). "Tonic," "Fuel" and "Food": Social and symbolic aspects of long-term use of psychotropic drugs. *Social Science and Medicine*, 15B, 521-533.
- Kind, P., & Carr-Hill, R. (1987). The Nottingham Health Profile: A useful tool for epidemiologists? *Social Sciences and Medicine*, 25(8), 905-910.
- Lamberts, H. (1990). The use of functional status assessment within the framework of the International Classification of Primary Care. In J. Froom (Ed.), *Functional status measurement in primary care*. New York: Springer-Verlag.
- Lamberts, H., Brouwer, H., Groen, A. S. M., & Huisman, H. (1987). Het transitie-model in de huisartspraktijk. Praktisch gebruik van de ICPC tijdens 28.000 contacten. *Huisarts en Wetenschap*, 30, 105-113.

Manca, D. (1989, February). *Study of miscarriage through qualitative and quantitative methods*. Paper presented at the Conference on Basic Sciences of Primary Care Research, Toronto, Canada.