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Hypothesis for a Theory about the Disorganized Health Problems in General Medicine: The Hidden Face of the Moon

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Abstract

The theoretical framework of general medicine has been developed in part from the scenarios derived from the "visible side of the moon": the hospital and the biomedical vision. But, in the "hidden face", 50% of patients treated in family medicine present, at any time, disorganized symptoms or diseases in which the patient presents us with complaints confusing , multiple, erratic, recurrent, and does not conform to patterns described. They are high entropy queries, with maximum uncertainty; with hidden data. This concept of disorganized disease overlaps with others such as frequent attenders, difficult patients, additional demands, multi morbidity and polypharmacy. This situation can overwhelm even experienced professionals. This article proposes a series of hypotheses about disorganized disease on this "hidden face of the moon" that has a different aspect: 1) The "entropy" of the symptoms and diseases is not due to the fact that is a difficult or rare disease; 2) Patients can maintain the quality of "chaos and balance" 3) They are people who consult us for diseases that, from a bio psychosocial point of view, are more complex; 4) There are certain characteristics of disorganized diseases, such as multiple psychosocial symptoms, with pain, digestive and genitourinary symptoms; 5) They have a hidden meaning and are not a simple coincidence; 6) It must learn to coexist with this "disorganization", and be attentive to the triggers; 7) It is not only escape valve from chaotic contexts; 9) They are important signals; 10) The presence of disorganized disease modifies the doctor-patient relationship. In the consultations that present "disordered" symptoms, these probably have a different meaning to what they would be given in an "ordered" query. To understand and order consultations with highly entropy diseases in general medicine, intelligence is needed and not so much evidence-based guidelines, nor is there a need to deliver these to the world of emotion or sensitivity, which would maintain the disorder.

Keywords: Family Practice; Family physician; Symptom Assessment; Complexity; Diagnostic Techniques and Procedures; Physician-patient relations; Communication; Continuity of Patient Care; Natural History of Disease

Introduction

In the general medical practice, the objective of the interview and the medical examination is to allow the doctor to understand the complaints, the symptoms, and the physical signs of the patient to integrating them in a coherent picture; In other words, the doctor's task is to discover the true nature of the condition, assess its severity and realize if it is chronic, progressive or if it is

susceptible to improvement; In addition, the doctor have to prescribing the appropriate treatment [1].

In this sense, medical students are taught (mainly by hospital specialists), that there is a set of signs and symptoms that define diseases, and that this defining set should be sought in the patient to make the diagnosis. But this approach is based on two fallacies that skew the concept of diagnosis in general medicine: that all cases of a certain disease have a certain set of symptoms and signs; In addition, the study of the disease is prioritized and the study of the patient's behaviour as a human being is forgotten, as well as the doctor-patient communication process [2].

But, the reflective general practitioner (GP) can observe in the consultation how the set of symptoms that could define a disease is, in general, much more complex, and thus can differentiate three groups of patients according to the types of problems or symptoms presented:

1. Patients "without disease": when the person who presents himself as a patient does not have a situation suggestive of illness. They assume 20-30%. They are preventive visits, pre and postnatal, vaccinations, health exams, etc. However, it is a good time to investigate the meanings of the patient, and make preventive bio psychosocial interventions.
2. Patients with "disorganized disease": They can suppose a large part of the patients attended in a normal day of GP consultation. There are symptoms that are sufficiently annoying for the patient to identify them and make him seek help from the doctor, even if these symptoms or health problems do not reflect a severe pathology. During these visits, the patient presents the disorganized symptoms and a psychological regression from the beginning of the consultation. It is observed that the balance of normal functioning is threatened by external pressures or internal psychopathology, and for this reason there is a regression to child models. For example, a 36-year-old woman with 4 children brings her 8-year-old son, who has been suffering from a cold for several days, and says: "Would you mind looking at my nose too? I have had some hemorrhage this summer." And soon after he says: "My husband is still not well; continue drinking and there are discussions...The children are nervous, and nothing is going well." The GP has here the option of giving less importance to the traditional diagnosis, and having his intervention focus on emotions, fears, feelings, communication problems, etc., exploring if the real point of alteration can be reached at one or several levels, and see if the situation can be remedied, and on the other hand, give less importance to the intervention on the cold of child, or the epistaxis of the mother. Or, on the contrary, GP can follow a biomedical course and focusing on achieving a traditional diagnostic (for example, common cold, and "nothing else"). This "disorganized complaint or illness" can evolve with a course of successive deterioration of the family balance, and could lead to an "organized disease", which, however, can take many forms in its presentation to GP.

The reflective GP knows that disorganized disease is not necessarily expressed as a set of severe or intense symptoms; on the contrary, it can appear as a "calm chaos". The presence of the problem originates a personal or family imbalance and the psychological regression, with certain relocation after the unexpected or abrupt turn of the patient's context causing a destructuring of what previously structured the existence. So, the patient may experience fear, pain, perplexity, stupor, isolation, etc. In this enigmatic and threatening new context the patient can become lost. The patient can enter a world different from the one he had previously, where many things were shattered, and it can be for him like getting lost from the road, like losing oneself in a forest [3].

3. Patients with "organized disease": when the GP and the patient agree on a diagnosis, organic or psychological, and the doctor-patient relationship is more or less oriented around the disease. For example, it is when the GP attends to a patient with peptic ulcer or an angor pectoris, or a major depression, and discusses about diet and drugs, without exploring the global bio psychosocial diagnosis. This represents an organized disease; that in which to make the diagnosis, apparently, we do not have to expose hidden data [4].

This situation could be summarized in that the GP can find:

A) Consultations in which the patient presents a highly organized clinical picture, without hidden data; they are consultations of low entropy and minimal uncertainty.

B) But also other consultations in which the patient presents us with complaints and a clinical picture that is confusing, multiple, erratic, recurrent, variable, unclear, diffuse, affecting several organs and systems, which does not improve, which does not conforms to orthodox clinical frameworks or patterns described and accepted. They are high entropy queries, disorganized, with maximum uncertainty; with hidden data. This concept of disorganized disease overlaps with other as frequent attenders, difficult patient, additional demands, multimorbidity and polypharmacy [5-10].

It has been reported that between 50-70% of the patients treated in family medicine present, at any time, disorganized symptoms or diseases; therefore, account for the majority of patients cared for in family medicine [11]. The degree of disorganization of a system is expressed as the degree of entropy. Entropy is "chaos".

These disorganized consultations are not "solid", but "fluid or liquid", with a state of clinical matter chaotic and disorderly.

At first glance you might think that within the concept of disorganized diseases could be included the most common diseases with difficult diagnostic because of their symptoms are nonspecific and variable, such as hepatitis C, irritable bowel syndrome, aneurisms, celiac disease, fibromyalgia, rheumatoid arthritis, multiple sclerosis, hemochromatosis / hemosiderosis, lyme disease, lupus, syndrome of polycystic ovary, pulmonary hypertension, hypothyroidism, chlamydia, fibrosis quística, diffuse cutaneous systemic sclerosis, Guillain Barre syndrome, Von Willebrand's disease, other rare diseases, etc. But does a disorganized presentation of symptoms mean that we are facing a disease that is difficult to diagnose because its symptoms are nonspecific? Or, can it be said that there are non-specific and variable symptoms that are really "specific" of disorganized diseases, and consequently this concept does not refer to diseases of difficult diagnosis or rare diseases (although they can be included in the "umbrella" of presentations with high level of entropy or disorganized)?

In this scenario, this article proposes to systematize a series of hypotheses that serve to verify and investigate more deeply in this topic.

Discussion

From the data presented above, a series of hypotheses are proposed to check and investigate in this topic (Table 1).

1. First hypothesis: the "entropy" of symptoms and diseases is not just because it is a difficult disease to diagnose or a rare disease. The true character of disorganized illness is that it is chaotic at the integral or biopsychosocial level: it is integral or biopsychosocial disorganization, not only due to unspecific biological symptoms.
2. A second hypothesis is that, in reality, the patients in general medicine can maintain this duality of "Chaos and Balance", and the GP has to live with it throughout the continuous attention. There are patients who, after attending to them for years, we have catalogued them as organized, ordered, or meticulous, and that at a certain moment they begin to consult us with high entropy, with complaints that are not well understood, strange behaviors, symptoms that they do not achieve verbalize and expose in a organized form, or repeated visits not well justified. And on the contrary, there are patients we know because of their chaotic use of visits, with repeated appointments and many times without finally presenting themselves in the office, with repeated consultations for insignificant reasons, poorly explained symptoms, confusing requests, etc., and that at a moment determined, they visit us with a clear, resounding, important, dramatic, serious reason, and that they present in a completely serene, clear and organized manner.
3. The hypothesis that patients with disorganized diseases, or are people who, or consult us for diseases that, from the biopsychosocial point of view are more complex. Living systems are subject to this tendency of disorganization, as organized dynamic systems are, and natural selection is the evolutionary force that achieves progress in evolution based on developing systems to combat the increase in entropy. The more complex a system is, the greater is the force tending to its disorganization. For these reasons, we could propose the hypothesis that patients with disorganized diseases are people and / or have more holistically more complex diseases [5,12].
4. Several hypotheses of categories or characteristics of the disorganized diseases that are presented to the GP have been described, and that are subject to future investigations to reproducing or not these findings: 1) They have multiple symptoms of many organs and systems; 2) They have psychological symptoms; 3) In half of the cases there is a moderate or severe degree of polypharmacy, and in a quarter of the cases severe multimorbidity; 4) They have psychosocial factors; 5) These patients are frequent attenders; 6) In nearly all cases there are symptoms of pain; 7) Very frequently there are digestive and genitourinary symptoms; 8) Many times there are a triggering or aggravating factor, often psychosocial, or an accident or the increase of multimorbidity and polypharmacy, and 9) Evolution could be towards three scenarios: a) Unchanged (50%); b) Decline (25%); and c) Serious and organized diagnoses (25%), especially when there are multimorability and polypharmacy [5,12] (Figure 1).
5. We also propose the hypothesis that the presentation of a disorganized disease in general medicine, has a hidden meaning, either in the own constellation of symptoms or, as a whole in the context of the patient; that is, it is not a simple coincidence without meaning, and it is not explained only as a vicarious expression of a difficult contextual situation of the patient, especially if this presentation of high entropy is repeated and prolonged in time.
6. As a consequence of the previous hypotheses, some lines of approach to the patient with disorganized diseases could be proposed. Thus, GP should learn to coexist with that "disorganization"; he or she must detect and manage psychosocial symptoms, pain, and digestive and genitourinary symptoms, which are consulted by the same patient at the same time or on successive visits, and should try to unifying these complaints in a vision that integrates them, even if

they are independent diseases, in the case of occurrence in high entropy contexts; also, GP must be alert to the triggers of disorganized diseases, such as the appearance or aggravation of psychosocial factors, accident or disorders of multimorbidity and poly pharmacy, GP must make as far as possible, early diagnosis, and to avoid complications and adverse effects. 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 [2].

7. In the consultation of family medicine, GP should eliminate deterministic ideal that he serves patients or people with an orderly and predictable psychic apparatus, but he must leave room for the idea of entropy, which is not a reversible and controllable process in all its variables, nor is it foreseeable in its processes, evolution and transformation [13]. Therefore, GP approach in high entropy consultations it is very difficult, and he must accept living with uncertainty "as if its patients were closed rooms", as the poet Rilke said [14].
8. Also, as a result of previous hypotheses, the GP must avoid three habitual preconceived ideas in the care of disorganized diseases: a) the idea that the presentation of high-entropy or disorganized diseases is only an escape valve of chaotic life contexts, and nothing can be done from the medical level, and perhaps not much from the social or psychosocial level; b) the idea that the presentation of disorganized diseases is a matter of chance, so it is not necessary to be very attentive to it; and c) the idea that the presentation of disorganized diseases has no specific meaning in the orthodox medical framework.

9. The presentation of disorganized disease in family medicine should be appreciated by GP because of there is more information in this kind of consultations than it seems: they are an important signal of a force that tends to disorganize a living system that had evolved based on developing systems to combat the increase in entropy, and now it crumbles sometimes with signs of invasiveness and aggressiveness, or maybe looking for a new order.

And finally, we propose the hypothesis that the presence of the disorder disorganized recurrent or in the long term, modifies the doctor-patient relationship (doctor-patient-context-disease relationship). When a person who feels sick, visits the doctor, and finally doctor establishes a diagnosis of illness, there is always a change in the doctor-patient relationship as a result of a third factor, the disease. Usually, doctors assume that the disease once diagnosed must be cured or improved (at least in the somatic sphere), but this is not always true. Only 10% of cases are "cured" in the sense that they do not need successive medical attention. On the contrary, the disease greatly influences the doctor-patient relationship. This field is formed by the personal and social contexts of doctor and patient, including beliefs and symbols; for example, an accident tends to provoke our sympathy, a venereal disease, our repulsion. The family usually incorporate their anxieties into this doctor-patient relationship, which as a general term can be of two types according to the disease: a) when it is an acute, somatic or psychic illness, the intervention of relatives tends to be a cry for help request ("Give me back my wife, etc."); b) in chronic, somatic or psychic diseases, the intervention is usually aimed at preserving the status quo ("We have adopted attitudes towards the patient, and he towards us, please do not change them").

This predictable and balanced doctor-patient relationship is not met in repeated consultations of high entropy. These patients fit even worse than usual in the diagnostic classifications (remember that patients of the general practitioner do not fit hardly ever properly into the traditional diagnostic categories), and it is very difficult to choose the right treatment or simply less bad, so many GPs become frustrated by their inability to "do something" for these people [11,15,16]. The disorganization and complexity of the symptoms and problems (repetitive complaints, without clear clinical significance, strange symptoms, never resolved, multiple, or generalized, without nuances, as in the query for "it hurts everything", etc.), can overwhelm even experienced professionals, and they producing feelings of anger, bewilderment, despair, frustration and impotence in the GP and in the patient. In addition, patients are often categorized as frequent consultants and "difficult" patients [17-20].

Conclusion

General medicine has its own theoretical framework, but in part it has been developed from scenarios derived from hospitals and the biomedical vision: one could say, from "the visible side of the moon". And from this evidence, diagnostic categories and guidelines for therapeutic approaches have been constructed. But, "the hidden face of the moon" from the Earth has a different aspect: the visible side is full of craters, mountains and large basalt plains, but the hidden side lacks this geography.

In this almost unknown context, it is not taken into account that the presence of disorganized consultations in family medicine is frequent fact. The GP finds that many, if not most, of their patients do not adequately enter the traditional diagnostic categories, and it is not easy to choose the appropriate treatment. So, many GPs

develop intuitive or experience-based methods to deal with this problem [21]. Others simply ignore it, but few GPs feel comfortable treating patients to whom "disease-focused" medicine has little to offer. High-level entropy or disorganized consultations increase this feeling of frustration in the GP.

The needs of patients may not be expressed in words, and they have to be discovered by the doctor's research and even intuition. The vital role of the GP lays in the interpretation of the unsolicited o disorganized calls for help: understanding the demand for help that means the consultation, whatever the reason for it, and helping patients find the right words to tell about their suffering; feeling that we have heard his distress message can be like a board where the shipwreck clings [3]. This gives value to general medicine compared to other specialties, and requires complex and refined techniques. This has also important implications in the GPs training [4].

The objective of the interview and the medical examination is to allow the doctor to understand the complaints, symptoms, physical signs of the patient and integrate them into a panoramic and coherent picture [6]. But, precisely, in the same way that the traditional medical model is useless to approach the emotional problems of the patient, the traditional psychotherapeutic model is not appropriate to treat those problems in general medicine. General medicine is guilty of importing lines of research and treatment useful in other fields, but not necessarily adequate in it [4].

Disordered diseases or high-level entropy is an umbrella term (Figure 1) that refers to various situations and symptoms that cannot be understood within the usual biomedical framework. The GP can achieve a certain degree of understanding using a biopsychosocial theoretical framework, centered on the patient, so that he / she can be more secure, comfortable and be more efficient [22]. On the other hand, the GP needs to maintain high capacity for reflection-action [23], especially in these hidden scenarios of great entropy, which despite being frequent, have not received the necessary attention, and where guidelines have not been developed.

This article, based on the few data reported, proposes a series of hypotheses to check on that "the hidden side of the moon" has a different aspect (Table 1).

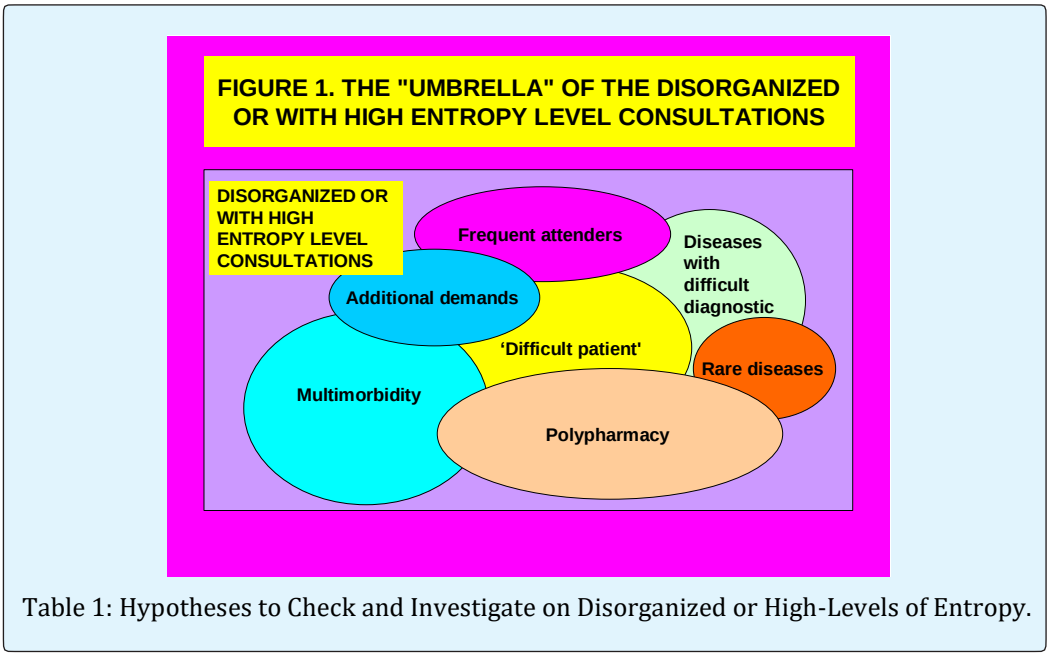

Table 1: Hypotheses to Check and Investigate on Disorganized or High-Levels of Entropy.

1. The "entropy" of symptoms and diseases is not due to difficult or rare disease
2. Patients in general medicine can maintain the quality of "chaos and balance", and the GP has to live with them throughout the continuous care.
3. Patients with disorganized diseases, or are people who, or consult us for diseases that, from the bio psychosocial point of view are more complex.
4. There are certain characteristics of disorganized diseases that are presented to GP: have multiple symptoms of many organs and systems, with pain, digestive and genitourinary symptoms; with psychological and social symptoms; there may be polypharmacy, and multimorbidity; These patients are frequent attenders; many times there are a triggering or aggravating factor, often psychosocial, or accident or multimorbidity and polypharmacy.

5. The presentation of a disorganized disease in general medicine has a hidden meaning and is not a simple coincidence without meaning.
6. Some lines of approach to the patient with disorganized diseases could be proposed: GP should learn to coexist with that "disorganization", detect and manage psychosocial symptoms, pain, and digestive and genitourinary symptoms, and be alert to the triggers.
7. The GP must remember that it attends patients who may present a disordered and unpredictable psychic apparatus, in processes that may not be reversible and controllable in all its variables
8. The presentation of high entropy or disorganized diseases is not only an escape valve of chaotic life contexts, nor is it a matter of chance or chance, nor are situations without any specific meaning in the Orthodox medical framework.
9. The presentation of disorganized disease in family medicine should be appreciated by GP because is an important signal.
10. The presence of the disorder disorganized recurrently or in the long term, modifies the doctor-patient relationship.

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Table 1: Hypotheses to Check and Investigate on Disorganized or High-Levels of Entropy.

Although the GP has to coexist with the "disorder", its objective must be to move in the direction of ordering the symptoms and signs, the reasons for consultation and disordered diseases so that they can be integrated and ordered in an intelligible set, which may not take accepted biomedical and quantitative forms, but other proper and specific patterns of this patient population. Just as the signs and symptoms may seem different in men and women, and there are symptoms and signs that are specific to the paediatric and geriatric population, in the consultations that present "disordered" symptoms, these have a different meaning to what they would be given in an "ordered" query [23]. To understand and order consultations and disordered or highly entropy diseases in general medicine, intelligence is needed, and not so much evidence-based guidelines, nor is there a need to deliver these reasons for consultation and these diseases to the world of emotion or sensitivity, which would maintain the disorder. Only the rational is intelligible. Possibly, the GP, like Goethe, should prefer injustice to disorder [24]. More research is needed on these dark areas of general medicine, since they represent at least half of the weight of this specialty.

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