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Interpretation of the Reasons for Consultation: Manifest and Latent Content. The Initiation of the Diagnostic Process in General Medicine

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Abstract

The task of the general practitioner (GP) is to discover the true nature of the health problem. The reason for consultation expressed by the patient is a manifest content. The GP must transform or complete those ideas that are latent or initially hidden. The latent content of the symptom / problem / motive may be incomprehensible at the beginning. When the initial manifest material of the patient is translated by the GP, we have a more understandable expression. This distinction between manifest and latent content makes special sense in two the motives / symptoms / problems that: A) although they pose a coherent material, cause some surprise or cognitive dissonance to the GP, and B) have no explanatory physiopathological meaning, nor are they comprehensible according to the usual theoretical frameworks. These types of visits may be a large part of the patients seen on a normal GP consultation day. In these motives / symptoms / problems the GP, instead of performing the "clinical method of the detective," uses a "biopsychoanalytical" method or tool, that is the beginning of the diagnostic process, which has at least 3 ways: 1) The GP acts by helping and avoiding disturbances in the patient's reflexive process; 2) The GP try of knowing the latent material by means of "reading the patient's manifest signs and symbols". The messages of our patients contain "facts" and "feelings", and we must be attentive and understand the emotional messages. The reason for consultation / symptom / manifest problem that the patient initially expresses is a "symbolic representation" (with universal and particular symbols); and 3) In addition, the doctor looks for what seems to be the cause of the patient's problem in the doctor-patient relationship itself.

Keywords: *General practitioner; General Practice; Family medicine; Physician-patient communication; Diagnostic techniques; Physician-patient relations; Symptom assessment; Biopsychosocial; Diseases; Patient-centred medicine care; Framework.*

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, the physical signs of the patient and to integrate 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, this interview should train the doctor to prescribe the appropriate treatment (1).

Consultation in general medicine expresses a "desire" of the patient, but this can be done or expressed more or less clearly. The reason for consultation presented by the patient in the consultation is a manifest content. The general practitioner (GP) must transform or complete those manifest ideas in the latent or hidden initially of the reason for consultation / health problem / symptom.

But, the vital role of the general practitioner lies in the interpretation of unsolicited calls for help. This gives value to general medicine compared to other specialties. It must be borne in mind that 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 (2).

In practice, it is therefore a matter of transforming a biopsychosocial material from one expressive form to another. The latent content of the symptom / problem /motive may be incomprehensible. The diagnostic work of the general practitioner (GP) begins with that type of expression "manifest". When the initial manifest material of the patient is translated by the GP, we have a more understandable expression: this is the beginning of the diagnostic process.

Therefore, at the beginning of a diagnosis in general medicine a "biopsychoanalytical" method or tool is used, not only biological, that could be said to be similar in part to that initially described by Sigmund Freud, for example, to interpret the dreams (3).

It is about making an idea / symptom / health problem of the manifest material more understandable that can be difficult to understand, in another idea or in a more intelligible material, linking the motive or symptom or problem initially exposed by the patient with other connections, and thus, finally replacing that initial manifest motive with a new motive that was latent and now is made explicit, and that comprehensibly includes an extension of the ideas presented by the patient.

Initially the patient may not be able to show connections from the manifest material presented to the latent content which is more integral and understandable, but during the diagnostic process can finally present numerous relationships, connections and interpretations that clarify the latent content. The GP acts by helping and avoiding disturbances in this reflective process of the patient.

In this scenario, this article aims to reflect and initiate a conceptual systematization of diagnostic clinical work in general medicine, as the process that goes from a certain explicit content presented by the patient, to another more elaborate and clear material that includes latent contents.

Discussion

Based on the process of transformation of the material from the obvious motives / problems / symptoms to the latent ones, this material can be classified into 3 categories:

1. Reasons or materials that in their initial manifest form are already understandable.

These are reasons to visit the GP that are likely to be accepted by it, from the start, without inconsistency or dissonance appreciably. They are predominantly visiting reasons / health problems / clearly biological symptoms. They do not cause surprise to the GP. The manifest content expressed by the patient already includes latent content, or there seems to be no latent content of interest.

These are materials or reasons presented by patients with "organized disease." 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 angina pectoris, or a major depression, and discusses about diet and drugs, without exploring the global biopsychosocial diagnosis. This represents an organized disease: that in which to make the diagnosis, apparently, we do not have to reveal hidden data, although presumably they can exist (2).

2. Motives / problems / symptoms that although they pose a coherent material and have a clear sense, cause some surprise or cognitive dissonance to GP. This cognitive dissonance causes the GP to be automatically motivated to strive to generate new ideas to reduce tension until the set of ideas and materials fit together, constituting a certain internal coherence to explain a diagnosis. Also here, the patient may experience some cognitive dissonance, being amazed at how that can happen to him, for which he has no explanation.

3. Those problems / motives / symptoms that have no explanatory physiopathological sense, nor are they comprehensible according to the usual theoretical frame works. They are incoherent, confused and meaningless. They are disorganized problems. They can suppose a great part of the patients attended in a normal day of consultation of the GP. It has been reported that between 50-70% of the patients treated in family medicine, at any time, disorganized symptoms or diseases; therefore, account for the majority of patients cared for in family medicine (4)

The concept of disorganized disease overlaps with other as frequent attenders, difficult patient, additional demands, and multimorbidity and polypharmacy (5-9).

It is clear that one way of knowing the latent material is "reading the manifest signs of the patient". The problem is that our patients' messages contain "facts" and "feelings," and we are less used to being attentive and understanding emotional messages. The feelings can be expressed verbally (the words used, the images used ...), but also non-verbally - tone of the voice, rhythm, posture, facial expressions, gestures or postures, the pattern of breathing , the direction of the gaze, the eye contact, etc. One must have the ability to "read between the lines" and interpret these minimal signs of the patient's dissonance or cognitive consonance, to avoid our own cognitive dissonance in the diagnostic process. As GPs, learning to see emotions is part of our daily work (10-13).

Therefore, instead of performing what has been described as "the detective's clinical method" (observe and look for "physical" evidences -without paying much attention to psychology- and to do a retrospective deductive reasoning, from those tests, to reconstruct "the crime" and delineate the physical attributes of the guilty), for the GP a different approach is suggested. The GP uses a "biopsychoanalytical" method or tool that is the beginning of the diagnostic process. This way of working makes it possible to help some patients who could not be helped in any other way (14). In this method, the doctor tries to observe how the patient talks, and what is behind their consultation. The tool has at least 3 ways: 1) The GP acts by helping and avoiding disturbances in the patient's reflexive process; 2) The GP try of knowing the latent material by means of "reading the patient's manifest signs and symbols"; and 3) In addition, the doctor looks for what seems to be the cause of the patient's problem in the doctor-patient relationship itself.

Obviously, the distinction between manifest and latent content only makes sense in the motives / symptoms / problems of types 2 and 3, and especially in those of type 3. In these types of reasons for consultation (types 2 and 3) the diagnosis is not can do successfully until the manifest content is replaced or complemented by the latent. Here, too, there is a connection between the confused and disorganized nature of the reason for consultation and the patient's difficulty in communicating it to the GP.

In the type 1 consultation reasons, the elaboration of the symptom or problem by the patient is not necessarily required to make it comprehensible to the GP. That is to say, manifest and latent content coincide practically. In any case, it must be remembered that every reason for consultation / symptom / health problem has biopsychosocial contents that are always latent to some degree: worries, fears, desires, etc. (15).

But the reasons we have called type 1, these latent contents are minimal or are not necessary for understanding and intervention on the problem, or it is not relevant to try to address the latent contents at that time. This would apply to acute processes, from the simplest ones such as acute tonsillitis to other serious ones such as an acute myocardial infarction. These types of motifs are biologically "simple", and have a clear connection with the biological level.

In the problems of types 2 and 3 always emerge facts in two or three directions that allow us to begin to glimpse the latent content of the manifest ideas. Here the GP must work to achieve a condensation or expansion with a panoramic view from the manifest content to try to expand the degree of understanding of the reason for consultation. Of course, this diagnostic process can take only one or, more usually, many successive visits, phases can be presented where the translation of a material manifested by the latent seems to be stopped, and conflicts can appear in the doctor-patient relationship, which represent in themselves part of those contents latent.

The process of achieving the latent content may be how to tune a dial (16), or as photographer Francis Galton did in the formation of his "family photographs." Galton devised a technique called "the composite portrait" produced by superimposing multiple photographic portraits of the faces of individuals to create a common face: hiding the various components, superimposing them and making it clear what was common among them, while the contrary details destroy each other. These composite portraits represent a useful metaphor for an ideal type or a concept of a "diagnostic group or natural class", it is a model, that is, an idealized simplification or representation of the systems found in the biopsychosocial world (3).

The application of this metaphor to the diagnostic process in general medicine, in the process of transforming an explicit material into a broader one that includes the initially latent content, would

be as follows: when in the course of diagnosis it seems that one should choose between the element A or B, according to this model what must be done is to substitute this process of choice for another of aggregation of A + B and take each factor as an independent starting point for the investigation. In the reason for consultation are presented, through a single product or initial material, several ideas or materials divergent or different or contrary, which must be separated and expanded independently, and finally, added.

Each of these elements of the reason for consultation has connections with several latent ideas. In addition, a single reason for consultation / symptom / health problem is represented by more than one content.

In the diagnostic process there is a shift from the initial manifest content to the latent content (**FIGURE 1**). In this way, it can often happen that, what appears at first glance to the GP as the most important or the clearest, when analyzing it is shown as an imprecise element, and another main material can be glimpsed. This deformation of the main material manifested in the latent content presented by the patient is usually produced by metaphors, comparisons, symbols, images, analogies, coincidences or poetic language, but also by unconnected clinical pictures, pieces of ideas or materials, ramblings, clarifications, objections, etc., and also by means of changes in the doctor-patient relationship.

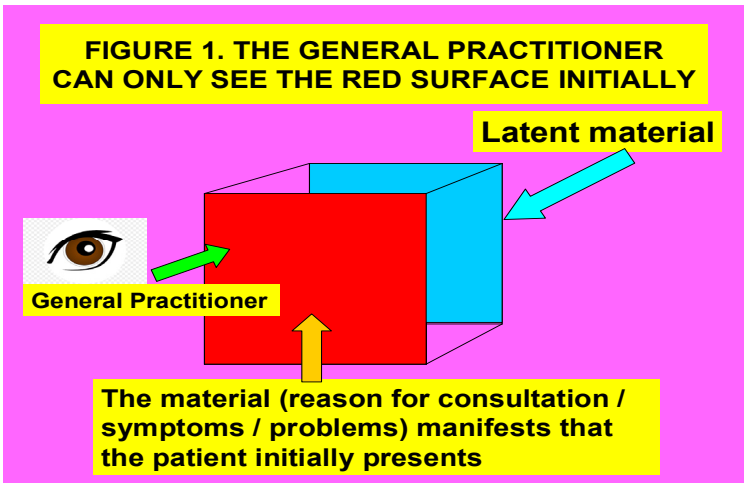

Fig 1. *The General Practitioner Can Only See The Red Surface Initially*

The diagnostic process goes through this path from the manifest content to the latent content through the following techniques: performing a condensation, fragmentation, displacement, selection, etc. In this way, new presentations of the query reasons that expose a new unit are created. Of course, it can also happen that the latent content remains unrepresented and remains hidden totally or in part.

This diagnostic process, from the manifest to the latent, is a transformation of one material into another, and it seems to represent a biopsychosocial epidemiological relationship of cause and effect. Therefore, the diagnostic process can be described as a process of displacement or transaction from an incomplete material to a more complete one, where there may be a causal relationship between the obscurity of some consultation reasons / symptoms / health problems, and the greater clarity of some of the latent ideas. It is necessary for the GP to make the patient see those cause-effect connections between latent content and manifest illness (or symptom / problem / motive), in order to improve or perform a treatment.

The symptoms that appear as a manifest motive are deformed; they are a representation, in part, of another latent material; what is presented may be unrecognizable. This deformation of the symptom or motive can be minimal and be shown without "repression" as in an acute process with a predominant biological basis, or they can represent "something else" with a certain "disguise" (for example, with anguish, etc.) , or show completely disguised or distorted, "censored" consciously or unconsciously, in the process in which the individual, in relation to their self and its context, perceives a dysfunction or alteration, and expresses it in a manifest manner.

The symptoms suppose a focus of attention since they indicate in some way the inner conflict or the evidence that the defensive systems have been activated. Symptoms are also the way in which the patient defines their problem: a way to make something accessible or available to someone. The patient can begin by describing his physical symptoms instead of saying how he feels. Frequently physical symptoms can be expressed through metaphors even if the patient is not fully aware of it. Symptoms occur in sets that collectively have a special meaning. If the symptoms can be easily understood in terms of being caused or related to some experience or event, they can be tolerated even if they are severe.

Understanding the meaning of the symptoms provides to the GP with a way to access the problem that the patient brings. The symptoms take meaning in the context, and can be seen as a silent form of communication with others. It may be important for the patient to cling to their symptoms as a way of defining themselves, and so, until a broad sense of self is established, when we try to eliminate the symptoms, they may even get worse. This is the reason why sometimes the drugs, which are a symptomatic treatment, often make the situation worse. GPs who work with patients who take drugs need to be more active to allow access to patients' feelings (17, 18).

The symptoms / reasons for consultation / health problems may be appropriate, unavoidable and even adequate; they can be both expressions of biochemical alterations, as symbols for the patient, expressions of the group context, and ways of dealing with a situation or event (whether or not he is aware of it). The expression of the symptoms depends on the previous psychological functioning of the patient, the severity of the deficit of the psychological function associated with the disease, the residual abilities, the adaptation and the coping of the functional deficits, as well as the influence of the colleagues, teachers, media, etc., the context (social expectations, social demands), and the doctor-patient relationship.

In addition, the type of doctor-patient relationship that is established also partially signals the content of the patient's latent material: manipulative, demanding, submissive relationship, masochist, victim, distant, with excessive familiarity or closeness, etc.

The clinical manifestations are colored by socio-cultural factors. Different cultures and belief systems have different ways of understanding clinical disorders, and the proper rituals to deal with them. Thus, there are differences in clinical diagnoses according to sex and social class (15).

Simplifying we could say that the reason for consultation / symptom / manifest problem that the patient initially expresses, is a "symbolic representation". And there are general symbols of universal diffusion valid for all individuals of a certain civilization, language, culture, etc., (such as cardiovascular symptoms that symbolize "sudden death", respiratory symptoms that symbolize "shortness of breath" and breathing is a symbol of living, Pain can mean punishment and guilt, any intense headache popularly means a brain tumour, announces the appearance of an embolism or expresses arterial hypertension, etc. (19), and particular symbols or the own symbols of each person.

In addition to these "particular symbols" and the possible variants of the "universal symbols", the GP does not know with certainty, at least initially, whether a certain symptom must interpret it symbolically or conform to its manifest literal meaning. But, the GP does know that not every reason for consultation / symptom / problem must be interpreted forcefully in a symbolic way; only some components of the manifest motive are susceptible to such analysis.

In the diagnosis (interpretation of a certain material) what can be done is to accept initially the hypothesis (probably inaccurate) of the validity of the manifest material, to progressively be able to order and complete the components shown with the latent, which are usually a rich material biopsychosocial, to form an intelligible and therapeutically approachable whole. To completely dispense with the analysis or interpretation of latent material can distort the diagnosis. In any case, the façade of the manifest query pattern usually does not cover completely the latent content and allows a provisional interpretation.

Therefore, in general medicine, the usual clinical characterization of diseases in other specialties is not adequate. The GP must look at the manifest symptoms as referents of another, broader material, not explained only by the initial manifest content. You could say that the disease is located "in-betweenness" (20).

Diseases are not a set of dichotomous diagnostic criteria, but are found between polarities in a continuous spectrum; Diseases belong to two or more worlds

at the same time, and to their transitions. From the fragile intermediate space between manifest material and latent content we can understand diseases, whose resulting complexity is due to an aggregation process (from A + B), and the GP must take each factor as an independent starting point for research. In this way, crossing these intermediate spaces, you can get to understand an initially incomprehensible material, and achieve comprehensive visions.

Conclusion

The GP must transform or complete those ideas that are latent or initially hidden. The latent content of the symptom / problem / motive may be incomprehensible at the begining. He must use a "biopsychoanalytical" method or tool, that is the beginning of the diagnostic process, which has at least 3 ways: 1) The GP acts by helping and avoiding disturbances in the patient's reflexive process; 2) The GP try of knowing the latent material by means of "reading the patient's manifest signs and symbols"; and 3) In addition, the doctor looks for what seems to be the cause of the patient's problem in the doctor-patient relationship itself (**FIGURE 2**).

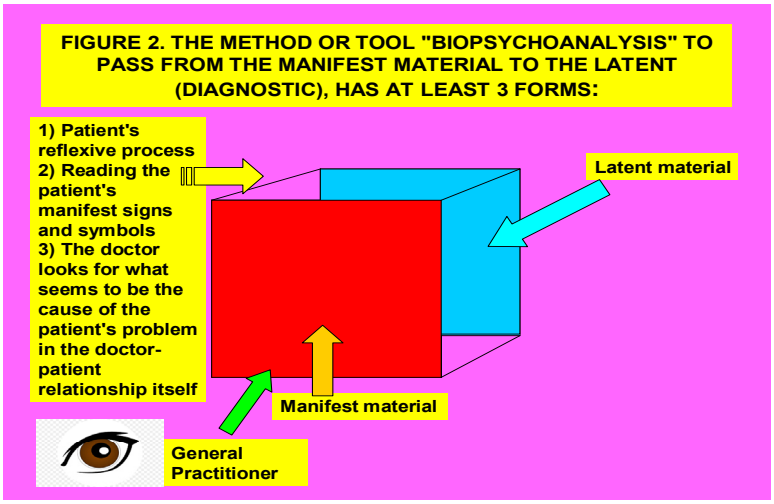

Fig 2. *The Method Or Tool "Biopsychoanalysis" To Pass From The Manifest Material To The Latent (Diagnostic), Has At Least 3 Forms:*

This "biopsycho-analytical" method that starts the diagnostic process is not a new magical tool, but simply a kind of doctor-patient relationship. When we are aware that pieces are missing to understand a set of materials, or that something emerges abruptly and gives rise to a new understanding between both, patient and doctor (which does not always mean reaching a moment of "peace" but sometimes the discovery, initially means anger, rupture of relationships, etc., to later restart that relationship in the same consultation or in another, but with a certain degree of learning achieved). It is not, at least only, as is often done, to reassure the patient: "You have nothing to fear", speaking to the patient in a calm tone, while taking his arm... "We will solve it soon, not I have doubts "(an only symptomatic approach or on the manifest material only, which can complicate or chronify a situation in the long run); but the GP and the patient also have to accept that the "resolution" can leave to patient affected, when facing all the latent material. The patient can be affected, but better equipped to address it (an integral approach, on the latent content).

It is not a panacea, nor a new form of treatment. It is completely included in the practice of general medicine, based on the tools it usually uses:

- The knowledge of the patient as a person.
- Support; it is the traditional role of the GP. Reassures, is optimistic, takes responsibility, and offers to alleviate or even cure. Of course, this should not be used as an alternative to adequate research and treatment of physical symptoms. It is a more neutral and deep support; accepting the patient and his conflicts; accepting that the patient will be inevitably "affected" when facing the latent material, but will be able to make him more prepared for the task.

- Relationship; especially continued relationship. It is a key element of psychotherapy.
- Deepening ("penetration, psychological intuition") ; it is in this search for the "depth" where support and relationship automatically unfold-extend-in the work of the general practitioner. You get to know the context of the patient, perhaps the family history, perhaps the anxieties of his mother as a child, etc.
- Encourages self-development and empowerment

References

[1] Michael y Enid Balint (19669. Técnicas psicoterapéuticas en medicina. México: Siglo XXI Editores SA

[2] Philip Hopkins (Editor) (1972) 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.

[3] Freud S (1966) Interpretation of Dreams. London: Sigmund Freud Copyright, Ltd.

[4] Turabian JL (1995) [Family and Community Medicine notebooks. An Introduction to the Principles of Family Medicine]. Madrid: Díaz de Santos. http://www.amazon.co.uk/Cuadernos-medicina-familia-y-comunitaria/dp/8479781920

[5] Turabian JL (2018) Disorganized Diseases: Are they a Simple Explosion of Random Energy and therefore Meaningless? A Cases Series Study in Family Medicine. Journal of Community and Preventive Medicine; 1(1). http://asclepiusopen.com/journal-of-community-and-preventive-medicine/volume-1-issue-1/1.pdf

[6] Turabian JL (2018) Additional Demands in the General Medicine Practice. Chronicle of Medicine and Surgery; 2(6): 285-7. https://scientiaricerca.com/srcoms/pdf/SRCOMS-02-00047.pdf

[7] Turabian JL (2018) Notes for a Theory of Multimorbidity in General Medicine: The Problem of Multimorbidity Care is Not in Practice, but in the Lack of Theoretical Conceptualization. Journal of Public Health and General Medicine: 1(1): 1-7. https://www.vagusinprosysonline.org/uploads/articles/15381163061133997244JPHGM-1-101.pdf

[8] Turabian JL (2018) Presentation and Approach of Disorganized Disease in Family Medicine. J Fam Med Forecast; 1(1): 1001. https://scienceforecastoa.com/Articles/JFM-V1-E1-1001.pdf

[9] Turabian JL (2018) Hypothesis for a Theory about the Disorganized Health Problems in General Medicine: The Hidden Face of the Moon. Epidemol Int J; 2(3): 000114. https://medwinpublishers.com/EIJ/EIJ16000115.pdf

[10] McLeod SA (2018) Cognitive dissonance. https://www.simplypsychology.org/cognitive-dissonance.html

[11] Festinger L (1957) A theory of cognitive dissonance, Evanston, IL: Row & Peterson.

[12] Festinger L, Carlsmith JM (1959) Cognitive consequences of forced compliance. J Abnorm Psychol; 58(2): 203-10. https://www.ncbi.nlm.nih.gov/pubmed/13640824

[13] Graesser AC, D'Mello S (2012) Chapter Five - Emotions During the Learning of Difficult Material. Psychol Learn Motiv; 7: 183-225. https://doi.org/10.1016/B978-0-12-394293-7.00005-4

[14] Balint M, Hunt J, Joyce D, Marinker M, Woodcock J (1970) Treatment or diagnosis. A study of repeat prescriptions in general practice. London: Tavistock publications.

[15] Turabian JL, Pérez Franco B (2012) [The symptoms in family medicine are not symptoms of disease, they are symptoms of life]. [Article in Spanish]. Aten Primaria; 44(4):232-236. http://www.elsevier.es/es-revista-atencion-primaria-27-linkresolver-los-sintomas-medicina-familia-no-S0212656711002848

[16] Turabian JL, Pérez Franco B (2011) [How is the door of understanding of the symptoms opened in family medicine?]. [Article in Spanish]. Semergen; 37 (10): 554-8. http://www.elsevier.es/index.php?p=revista&pRevista=pdf-simple&pii=S1138359311003248&r=40

[17] Hammersley D (1995) Counselling people on prescribed drugs. London: Sage Publications.

[18] Turabian JL (2018) Drug Prescription Modifies the Doctor-Patient Relationship in General Medicine. Arch Fam Med Gen Pract; 3(1):66-9. https://www.scholarlypages.org/Articles/family-medicine/afmgp-3-012.php?jid=family-medicine

[19] Turabian JL, Pérez-Franco B (2014) [Journey to what is essentially invisible: Pysochosocial aspects of disease]. [Article in Spanish]. Semergen; 40: 65-72. http://www.elsevier.es/es-revista-medicina-familia-semergen-40-articulo-viaje-lo-esencial-invisible-aspectos-S1138359313000580

[20] Turabian JL (2018) The Condition of In-Betweenness is a Structural Characteristic of Chronic Disease. Analogies for Understanding. SF J Chron Dis 1:2. https://www.scifedpublishers.com/open-access/the-condition-of-in-betweenness-is-a-structural-characteristic-of-chronicdisease-analogies-for-understanding.pdf

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