

Development and policy

Understanding unexplained physical symptoms in primary care

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Introduction

Patients presenting with symptoms for which doctors can find no satisfactory explanation are common in primary care. They account for about one-fifth of all consultations, and are the most likely to be frequent attenders.^{1,2} They have twice as many disability days as patients with a range of common medical conditions.³ They receive disproportionate levels of symptomatic investigation and treatment, which is largely ineffective and sometimes iatrogenic.⁴ In the United States, patients with unexplained symptoms make 33–50% more primary care visits, produce 20–50% more outpatient costs, and have one-third more hospitalisations than other primary care attenders.⁵

These are not simply practical problems. Patients with unexplained symptoms are a frequent source of frustration to family doctors.⁶ Patients often feel unsatisfied with these consultations as well, considering that their doctors can neither understand nor manage the problems they present.⁷

Frank is a typical – though largely fictitious – example.

Frank consults me about his stomach pain. He finds it hard to pin down exactly where it is. 'It starts with my tummy button but spreads all over one side'. It has been off-and-on for about 18 months. It lasts around a day at a time, sometimes longer. He finds it hard to get to sleep because he has to try to lie in a way that eases the pain. When it flares up he feels very low, thinking 'oh no, this is starting again'. When it's not happening he feels anxious that that it might start again.

He has found himself noticing other problems lately, although he is aware how busy I am today and not sure whether I will want to hear about

them as well as his stomach. He had a migraine the other day. He used to get them a lot but has been free of them for a few years. He has also had bad acne for about three months. Whatever he does, the spots won't go away. He has a mole on his arm which might have grown a little over the last few months. At night he has throbbing in his leg sometimes. He is worried what it all might be.

He has missed several weeks of work recently, and often finds it too much trouble to socialise with his friends at weekends. He used to enjoy painting wildlife scenes with oils and acrylics, and gained several local commissions, but hasn't picked up his brush in the past two years.

Frank has tried to work out what the cause of his stomach pain is. It doesn't seem to link to diet. He has talked to people about it. A previous doctor suggested he had bruised his ribs. Another doctor had suggested gallstones. This is his ninth consultation this year. Over the past two years, he has had blood tests and scans of his gall bladder and liver, but these were all normal. Friends have suggested it could be his appendix, and his grandmother thinks it is probably his 'nerves'. He had 'flu last year and is wondering if he might have a lingering virus. He also wonders if stress might be involved. His wife had an affair three years ago but they have moved house since then and are trying to put those problems behind them. 'But the pain is horrible' he says 'so it can't just be stress'.

The two questions I wish to address in this paper are:

- how can Frank's problems be understood?
- how can I help Frank, rather than make matters worse for him?

Understanding Frank's problems

If we start from the premise that Frank is very unlikely to have a significant physical illness – given the intermittent nature of his abdominal symptoms and the plethora of negative investigations – our subsequent understanding will depend on the perspectives we adopt.

Psychiatric diagnoses

If Frank were interviewed by a psychiatrist, he might well be considered to have a DSM-IV *somatoform disorder*.⁸ He has symptoms which are not fully explained by a general medical condition, the direct effect of drugs or another mental disorder, which cause him clinically significant distress, and which lead to impairment of social, occupational and other areas of functioning. He does not fulfil DSM-IV criteria for *full somatisation disorder*: for this he would need to complain of at least 12 different symptoms from a list of 37, and to have experienced them over many years. He does meet diagnostic criteria for *abridged somatisation disorder*, since he presents at least four somatic symptoms.⁹ These criteria are gender specific: women need to present at least six relevant physical symptoms before they can be offered this diagnosis!

He might also be a candidate for a diagnosis of a *functional somatic syndrome*, such as irritable bowel, fibromyalgia or chronic fatigue. Barsky and Borus characterise these syndromes by the commonality of the symptoms, suffering and disability they generate, rather than by demonstrable tissue abnormality.¹⁰ Suffering is exacerbated by self-perpetuating cycles in which somatic symptoms are incorrectly attributed to serious abnormality, reinforcing the patient's belief that he has a serious disease. However Frank does not fully fit this picture, since he does not have a fixed view about a pathological aetiology of his symptoms. He is prepared to entertain a wide variety of physical, social and psychological factors as possible causes.

It is likely that Frank meets current diagnostic criteria for an *anxiety disorder*, and possibly also for *major depression*. He describes himself as feeling low, and he certainly worries a lot. Symptom amplification – the tendency to attribute greater intensity or significance to physical symptoms than appears to be warranted by the available clinical evidence – is commonly the result of psychological distress.¹¹ There is now a considerable amount of empirical evidence suggesting that unexplained physical symptoms

frequently co-exist with mood or anxiety disorders. This co-existence may be cross-sectional, when all these symptoms appear together at the same time;¹² or it may be longitudinal, in the sense that one set of symptoms is followed closely in time by another.¹³

It may be possible to persuade Frank that his main problems are psychological, and to offer him treatment for anxiety and depression. This is the basic premise behind the IMPACT programme, where patients with evidence of symptom amplification in a range of chronic conditions are screened for depression and then offered either antidepressant medication or problem-solving treatment.¹⁴

However, many patients with unexplained symptoms do not accept the assertion that their problems are primarily psychological.¹⁵ As Frank says, 'the pain is so terrible it can't just be stress'. And as doctors, we must be careful to avoid shoehorning our patients' problems into categories that make life easier for ourselves, while failing to address their real concerns.¹⁶

The impact of healthcare

The ways in which Frank experiences and describes his symptoms are not exclusively the product of his own mind or body. They are also affected by his interactions with healthcare.

Across the world, patients vary considerably in the extent to which they report somatic symptoms in relation to depression. This variation is strongly dependent on the healthcare systems with which they interact. In a World Health Organization (WHO) study of psychological problems in general healthcare in 15 different countries, somatic presentations were significantly more likely in centres where patients lacked an ongoing relationship with a primary care physician, compared with those primary care centres where most patients had a personal physician.¹⁷

The presentation of physical symptoms is also dependent on the characteristics and attitudes of physicians. As we have seen, we family doctors are not always very keen on patients like Frank. They express symptoms which are difficult for us to characterise and manage within the parameters of general practice, and we think they consult us too often. We are wary about their motives for presentation, and doubt the legitimacy of their symptoms.¹⁸ Frank seemed to be aware of this tension in his consultation with me, since he was uncertain how many of his current problems he should mention.

We often try to contain the situation by *normalisation*, stressing to the patient that there is no serious disease, that symptoms are likely to be benign or self-limiting, and that there is no need for healthcare intervention. However, more often than not this

tactic simply exacerbates the situation, prompting patients to provide further evidence for the importance of their problems.¹⁹

Although patients like Frank tend to present us with a complex variety of problems and cues, as family doctors we are much more likely to pay attention to patients' physical symptoms than we are to their manifest psychological or social problems.²⁰ We are also more likely than our patients to recommend investigations, somatic treatments or referrals. In a real sense therefore, it is we doctors who are encouraging – or even creating – somatisation in our patients.²¹

The issue for the patient now becomes: how can I make sure that my suffering and concerns are taken seriously?⁷ The issue for the doctor becomes: how can I contain this patient? This can all too easily develop into a spiral of confusion, conflict and even downright hostility. With no exit point in sight, the doctor–patient relationship itself becomes a chronic problem.²²

Helping Frank (and myself)

How can I help Frank, and avoid becoming embroiled in a mutually destructive series of consultations with him?

I think the starting point is to acknowledge that his problems do not necessarily – or completely – lie within himself, and that his interaction with health-care has also played its part. For this reason I prefer to use the term *medically unexplained symptoms* to describe the problems that I am discussing with Frank. This phrase neatly encapsulates the fact that both of us have a problem here: Frank has symptoms which cause him to suffer; and my professional expertise is challenged because I cannot adequately explain them.

Second, it is important to be aware of what patients like Frank want or expect from doctors like me. They do not generally have high expectations of cure. They are aware that their problems are complex, and that medicine is limited in what it can do to overcome them. Instead, they are looking to us for acknowledgement of suffering, for emotional support, and for explanations which enable them to make sense of their problems.²³

Peters and colleagues have identified three key elements of successful consultations, as seen from the perspective of patients with persistent unexplained symptoms.²⁴ The first element is *alliance*, the sense that doctor and patient are in this together:

I'm not blaming him [the GP]. We're in the same boat. Neither of us knows what it's about.

The second element is *exculpation*, the ability to absolve the patients from blame for their current predicament, something which the powerful status of the family doctor still enables us to do. And the third element is a *convincing explanation*.

To be convincing to patients like Frank, my explanations need to be presented within the context of a tangible – usually physical – mechanism, which validates the bodily nature of his symptoms. They should be also grounded in the patient's own concerns.¹⁹

Here is a genuine example of such a convincing explanation, provided by a doctor (Dr) for a female patient (P) also concerned about an abdominal pain. The doctor makes deliberate and elegant use of the ambiguous meaning of the word 'nerves' in order to bring physical and psychosocial problems together:

Dr: The only thing that fits is, it's the sort of pain you get with shingles because it comes around in that pattern.

P: Yes, yes.

Dr: And that's sometimes irritation of the nerve endings.

P: That's what somebody else, me Nan says, 'It could be your nerves'.

Dr: I don't mean your emotional nerves, your actual physical nerves that come round your body – but it could be made worse by stress and things like that.

P: I mean I'm obviously one of them people that are highly strung anyway, I know that. I'm not, I'm not you know come day go day like laid back person, I'm quite like you know, everything's got to be done at that day, at that time.

Dr: Have you had any sort of relaxation to see if that would help your pain?

This approach is similar to those proposed in programmes of *retribution* training for family doctors, which identify four key stages in the consultation: enabling the patient to feel understood; broadening the agenda beyond the presenting physical symptoms; making the link between physical symptoms and an underlying psychosocial or lifestyle explanation; and negotiating further management.²⁵ It is important to remember that many patients with unexplained symptoms are already aware of the wider context of their problems.²⁰ Frank, for example, can see that his pain may in some sense be linked to his wife leaving him. So the success of retribution training may lie not in changing patients' perceptions, but in encouraging us doctors take this broader view, rather than focusing on the somatic.

Whenever possible, my explanations should provide Frank with the opportunity to do something himself about the problems he faces. I should be aiming to build up his sense of *personal agency*.¹⁶

Patients with irritable bowel syndrome, for example, are receptive to models of self-care which acknowledge the intensity of their bodily experiences, that stress has physical as well as psychological dimensions, the disruption that their symptoms cause to their to social and domestic roles, and their consequent loss of control.²⁶

By taking an approach based on facilitated self-management, I would be helping Frank to acquire the skills and confidence to manage his own illness.²⁷ At the same time I would reduce the burden of expectation on myself. If I can be reassured that Frank does not expect me to cure his problems, I may feel less of a failure, and so become less defensive in my dealings with him. I may be more able to respond empathically to his need for emotional support and understanding, and think with him about what steps he can take to make life better for himself.

Next time we meet, instead of worrying about which new specialist to refer him to, perhaps I should ask him to tell me about his wildlife paintings, and encourage him to pick up his brush again.

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CONFLICTS OF INTEREST

None.

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